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Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Improving Regional Health Care Markets

Insights from *Aligning Forces for Quality*

September 24, 2012

Robert Wood Johnson Foundation

John R. Lumpkin, MD, MPH

Director of Health Care Group

Robert Wood Johnson Foundation

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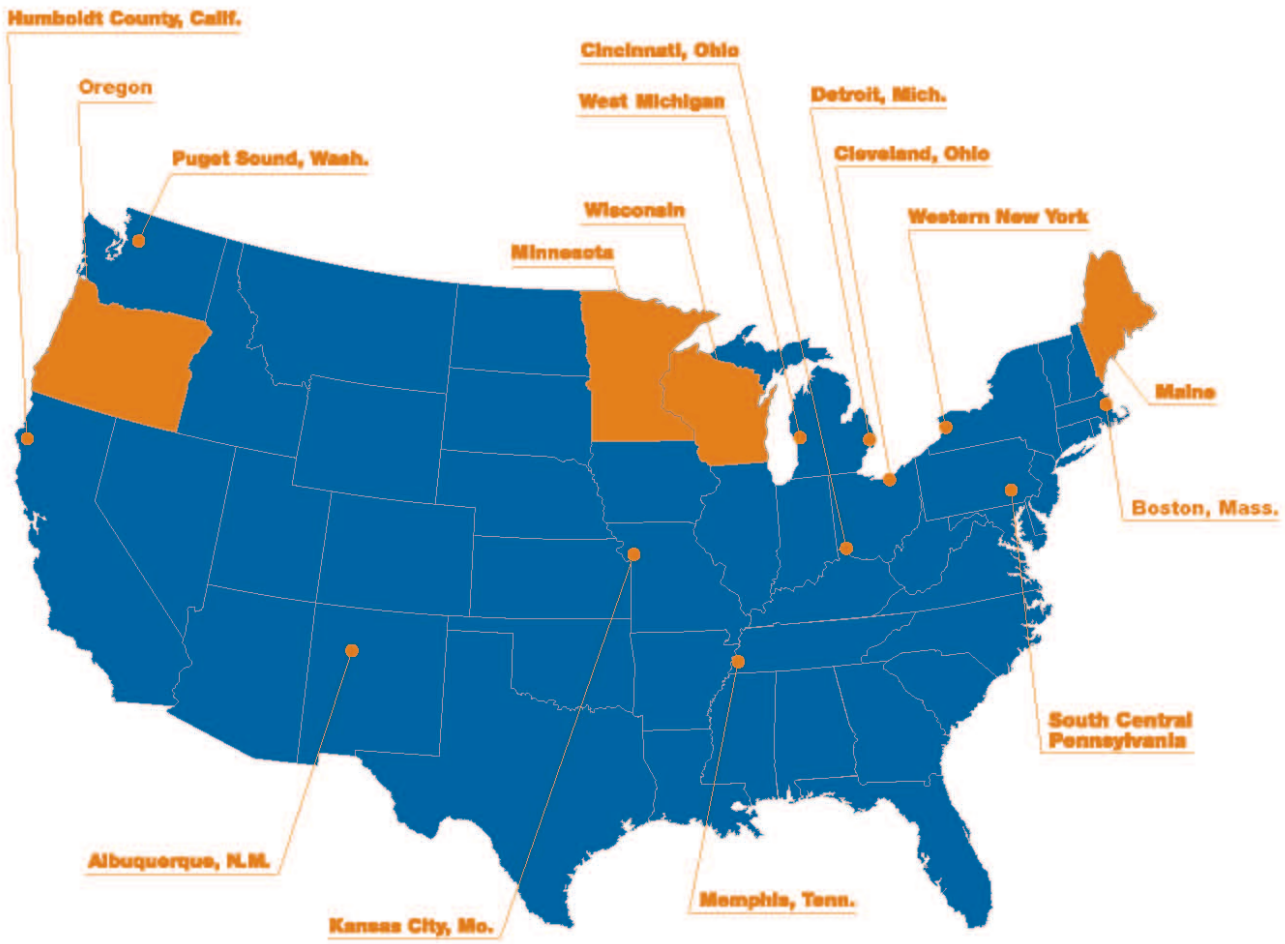

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Aligning Forces:

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16 communities

37 million people

12.5 percent of the U.S. population

590 hospitals

31,000 primary care physicians

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Anne Weiss, MPP

Director of Quality/Equality Team

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Dennis P. Scanlon, PhD

Professor of Health Policy & Administration

Pennsylvania State University

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The "Local Chapter" is Often Missing From the Story of Health Reform

"Building alliances that succeed at the local level is hard work. They must overcome intense competition among providers, divergent interests between providers and payers, and deficits in information and understanding among consumers. Although the will to work together may exist, the knowledge of how to do so, how to build systems and processes that actually change quality and efficiency, is scarce. No matter what global changes in policy are instituted in Washington or state capitals, they will not succeed unless the kinds of alliances and programs envisioned by the Robert Wood Johnson Foundation arise and flourish. "

Dr. David Blumenthal, Samuel O. Their Professor of Medicine and Professor of Health Care Policy, MA General Hospital/Partners Health System and Harvard Medical School

AF4Q Evaluation is Designed to Tell the "Local Story" of Health Reform

- Key question to be answered – Can local multi-stakeholder efforts catalyze improvements in the health care system?
- Large scale independent evaluation team comprised of faculty from the Pennsylvania State University, University of Michigan, University of Minnesota, and Northwestern.
- Longitudinal evaluation using multiple and mixed research methods and a variety of data sources
- Goals of the evaluation are to both estimate the impact of the initiative and to document lessons for policy makers, health practitioners and communities
- The issue of AJMC released today tells the "AF4Q Story" through:
  - Dr. Blumenthal's guest editorial
  - Six "perspective" pieces (i.e., op-eds) by national experts with some understanding of AF4Q and its specific areas of focus
  - Eight original peer reviewed research articles including:
    - Articles describing the AF4Q program and interventional work and the evaluation study design
    - An article describing 'mid-term' observations and policy recommendations
    - Articles describing the alliances' work in specific areas (e.g., QI, CE) and the impact of that work

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MANAGED CARE®

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The Aligning Forces for Quality Initiative: Early Lessons From Efforts to Improve Healthcare Quality at the Community Level

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Debra L. Ness, MS

A Supplement to *The American Journal of Managed Care* www.ajmc.com PRCJ A413

Example Findings & Observations

- AF4Q communities have created more information about physician quality then previously existed. The broader impact of this increased transparency is still to be determined.
- Multi-stakeholder support and participation in the alliances has been maintained despite changes in economic and political environments . This suggests a willingness to cooperate at the local level to improve the system.
- There are opportunities to better integrate federal and state policy efforts with the work of community alliances.
- Those 'on the ground' doing the work to improve health care have important insights that are not well understood or discussed in the mainstream media. These stories about challenges and barriers to making health care better should be told and could paint a more realistic understanding of the complexity of improving health care systems.

"Aligning Forces for Quality"
Evaluation

PENNSTATE

For More Information on the AF4Q Research and Evaluation, contact:

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More information regarding AF4Q evaluation team at: http://www.hhdev.psu.edu/CHCPR/activities/project_alignforce.html

Robert Wood Johnson Foundation

Randall Cebul, MD

Director

Better Health *Greater* Cleveland

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Shortening the Path to a healthier place to live and a better place to do business

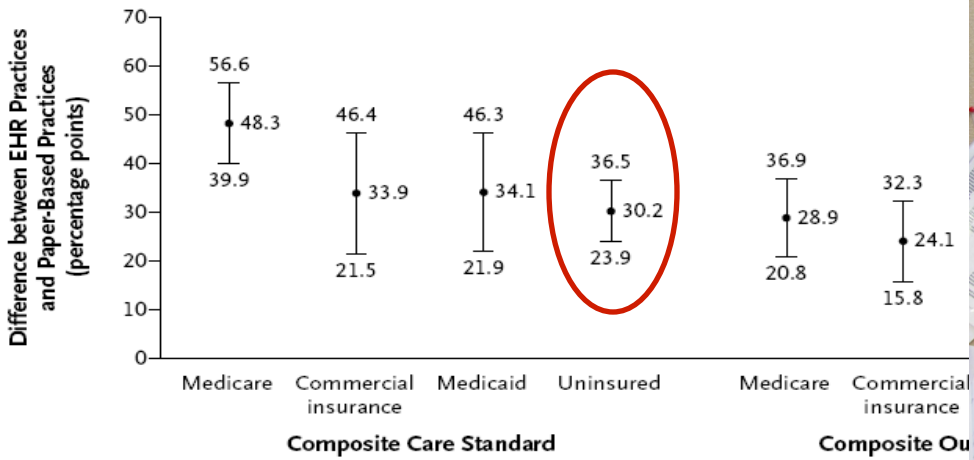
- Shared vision – 600+ providers, 69 sites
- Shared commitment to patient-centered care
- Shared conditions & measures – Diabetes, HBP, heart failure; insurance, race, language, income, educational attainment
- Shared data – EMR-catalyzed
- Shared best practices

We've documented that EMRs help shorten the path (*better achievement, faster improvement*) and that all patients benefit

SPECIAL ARTICLE

Electronic Health Records and Quality of Diabetes Care

Randall D. Cebul, M.D., Thomas E. Love, Ph.D., Anil K. Jain, M.D., and Christopher J. Hebert, M.D.



Dr. Mostashari, National Coordinator of HIT for DHHS visited to learn HOW

Better Health Greater Cleveland

Our Learning Collaboratives shorten the path:

"Sharing Best Practices, Competing on their Execution"

March 23, 2012 Summit at CC/Lyndhurst

Better Health Greater Cleveland

Disseminating a Best Practice

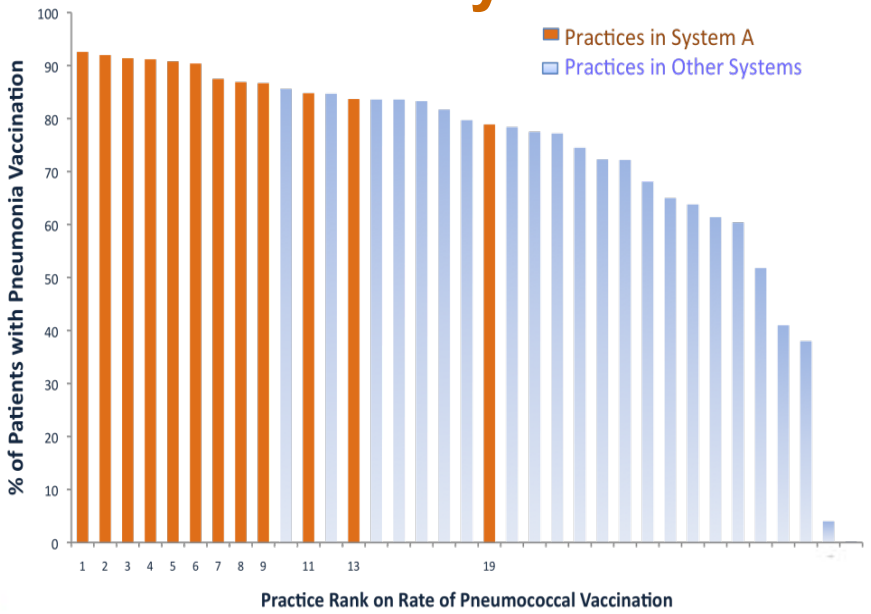
Vaccinations in Diabetes

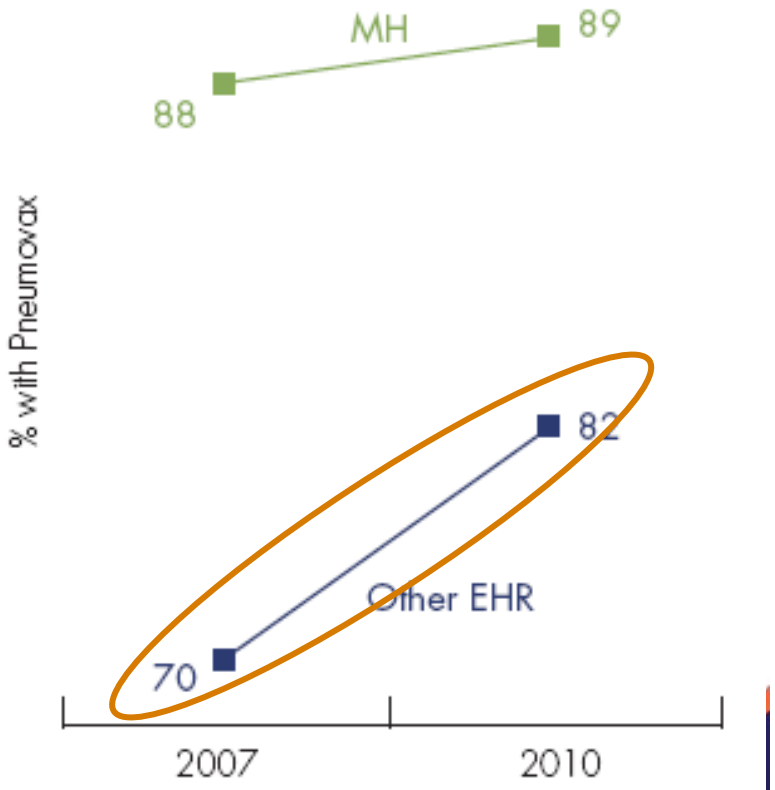
2007 → 2010

2007

Who are those guys?

How did they do this?





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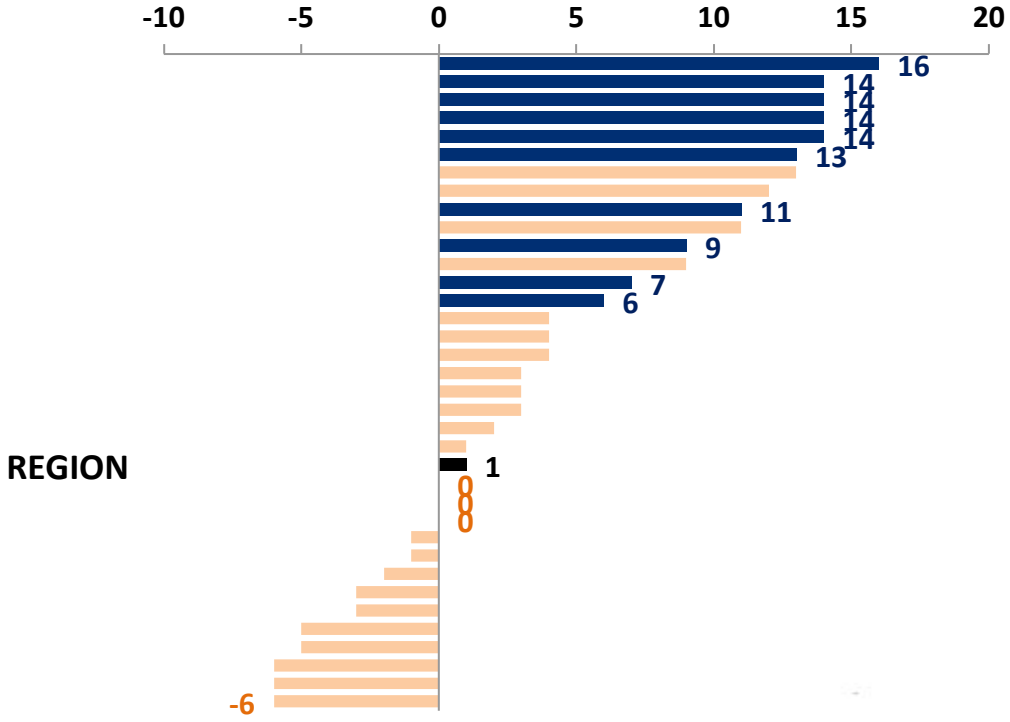
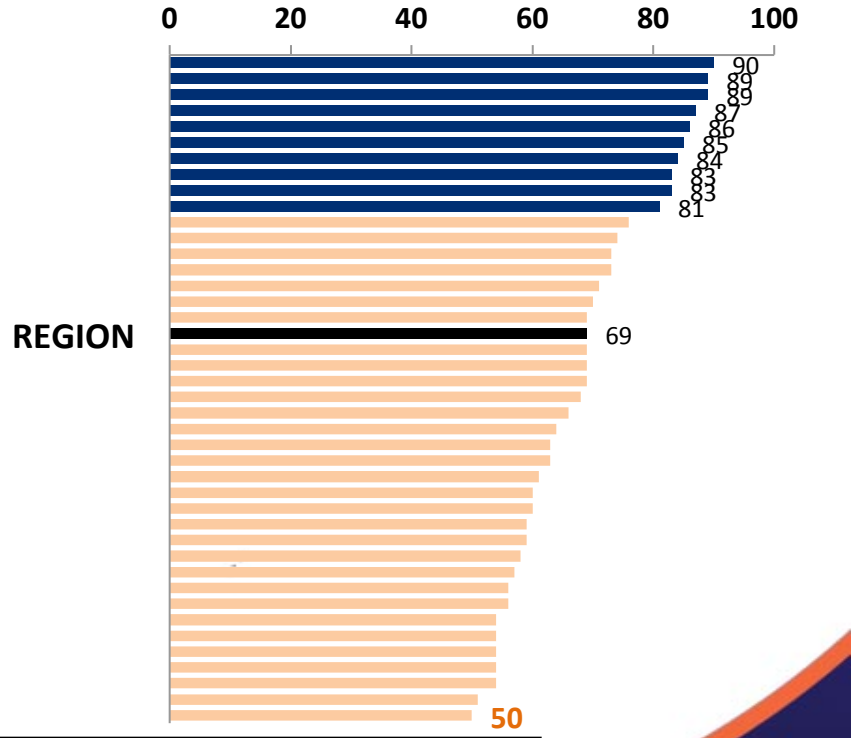
2011-12: Finding Best Practices for Good Blood Pressure Control

***Bright Spots* for *improvement*:**
The top 6 were from 1 system



***Bright Spots* for Good BP control:**
The best 10 were from the same system



"What system is this? How did they do that?"

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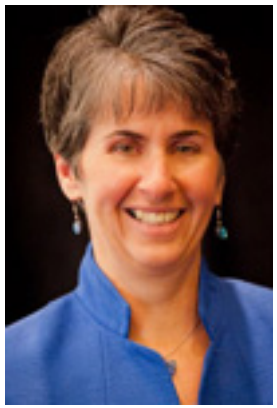

Lisa Letourneau, MD, MPH

Executive Director

Maine Quality Counts

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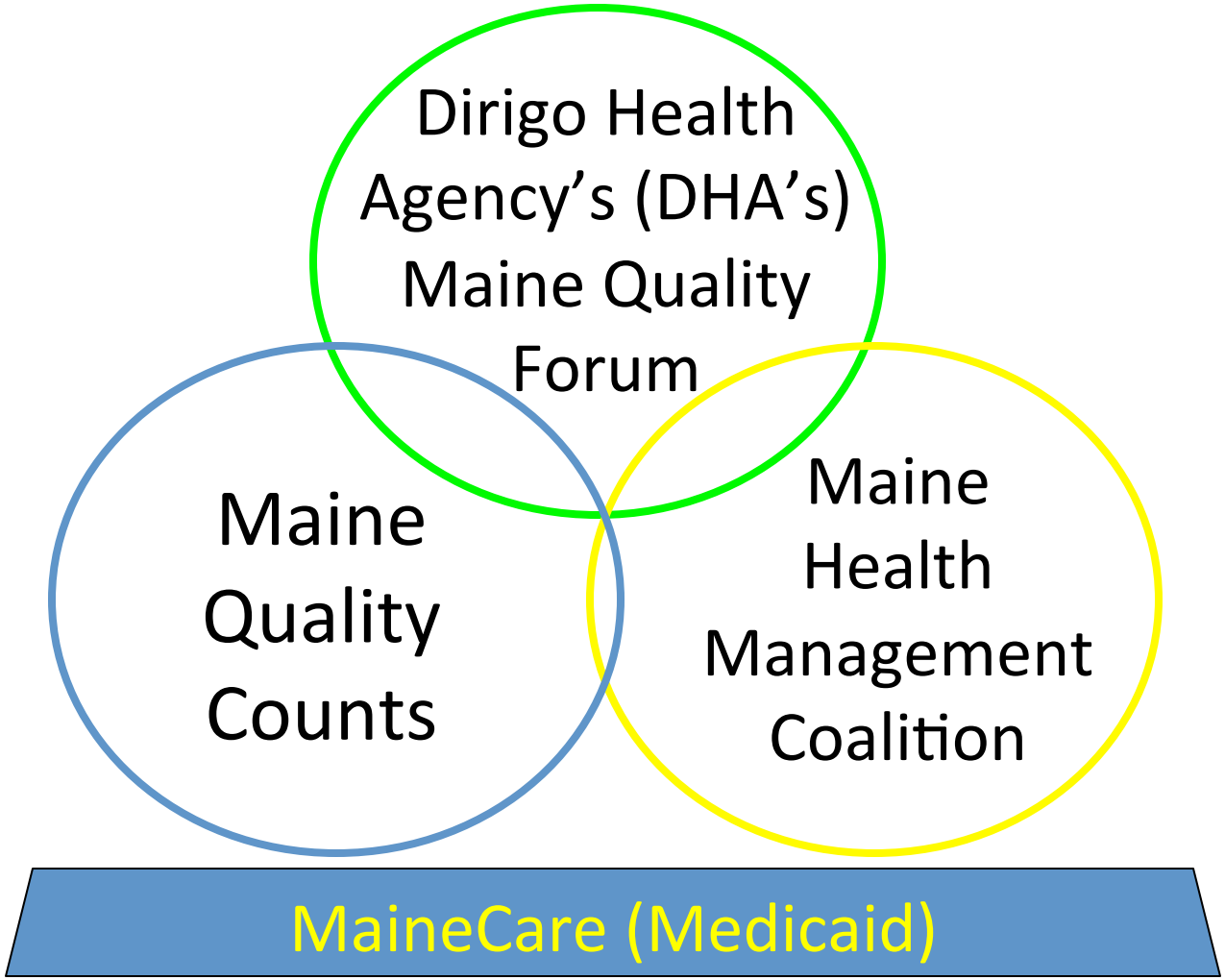
Maine AF4Q & PCMH Pilot Leadership



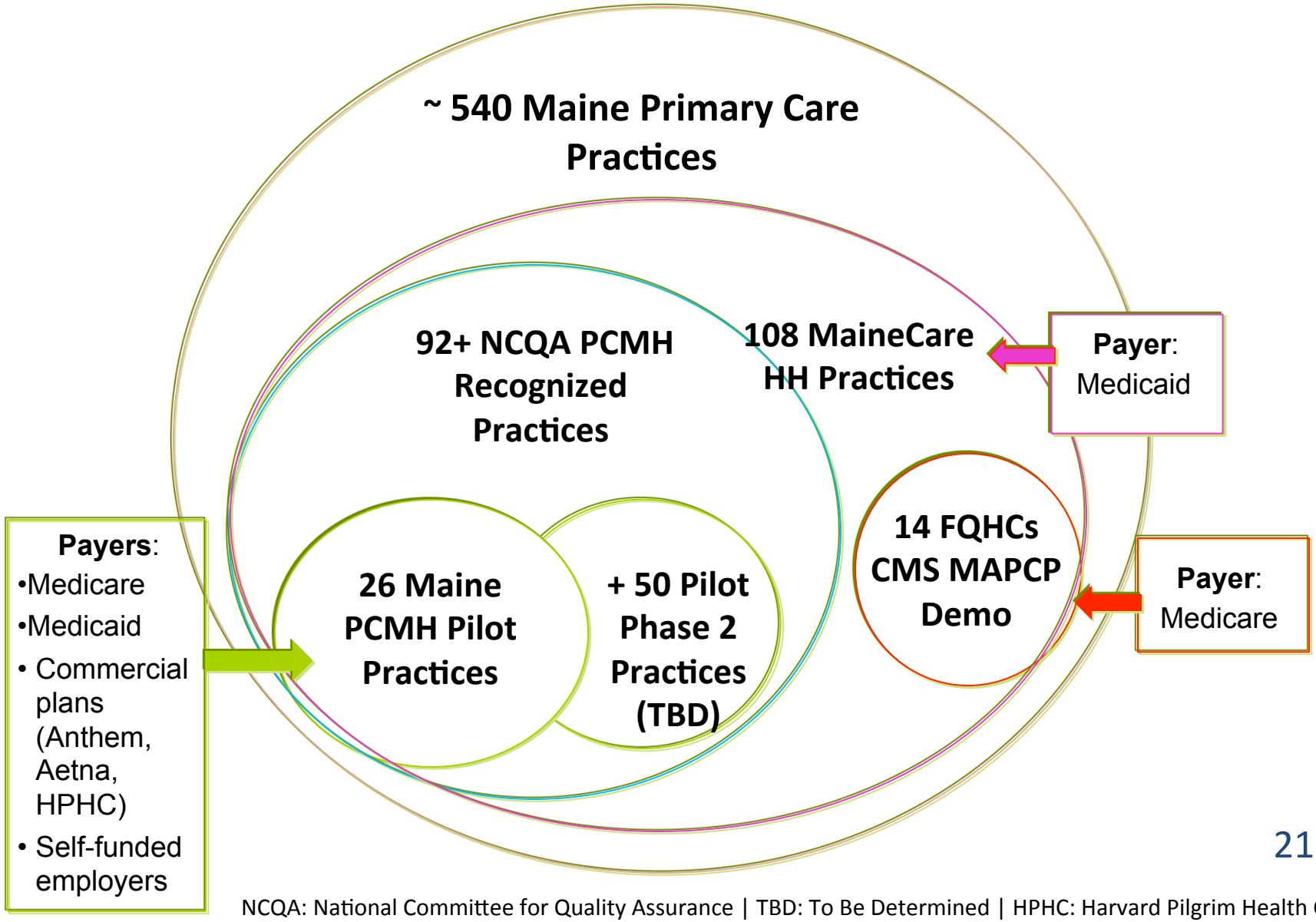
Vision for a Transformed Healthcare System

Healthy, productive, connected people & families…

Receive healthcare from highly functioning "accountable care organizations"…

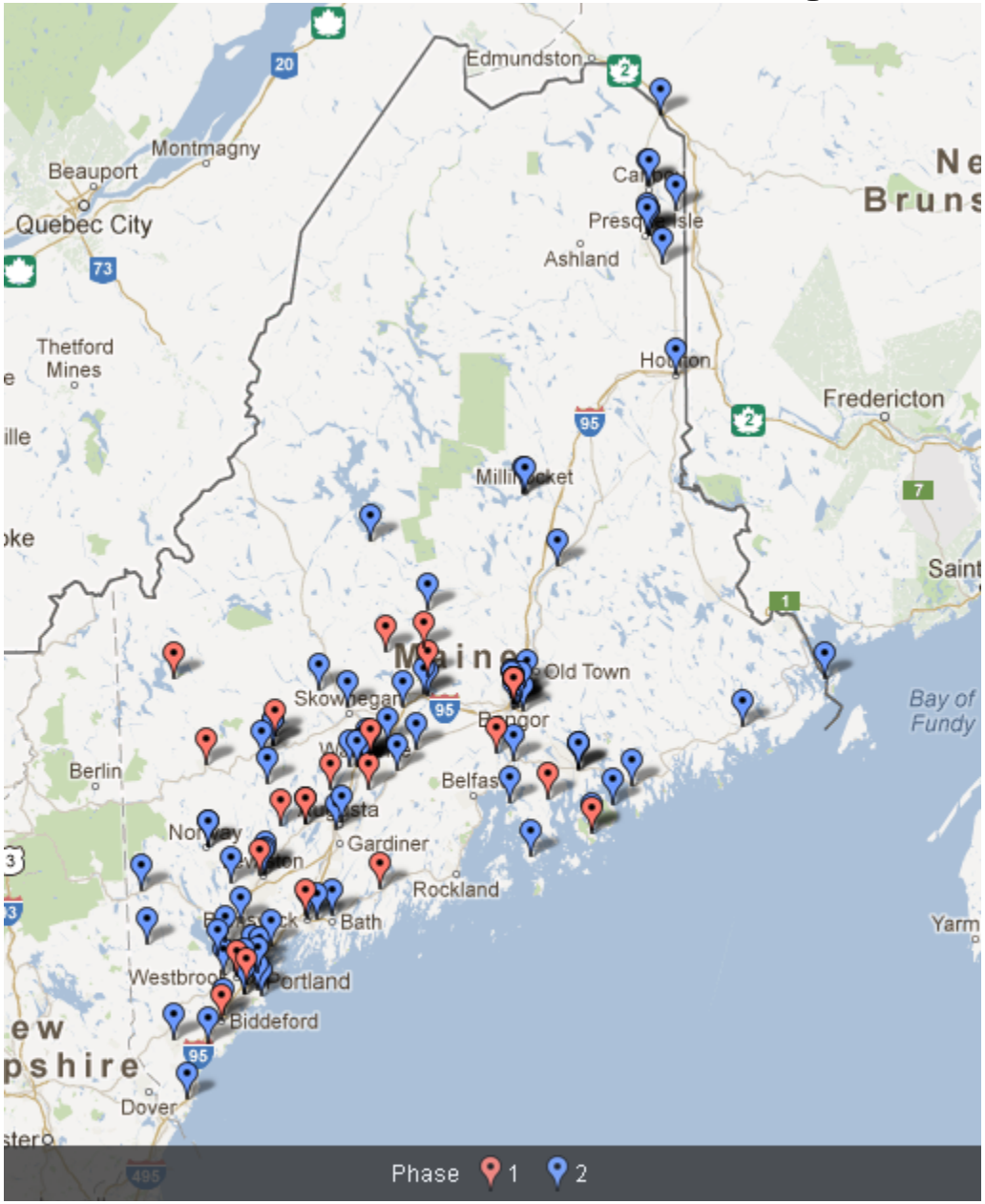
That are built on a robust, well-supported & inter-connected primary care base

Maine's Medical Home Movement



NCQA: National Committee for Quality Assurance | TBD: To Be Determined | HPHC: Harvard Pilgrim Health Care

Maine PCMH Pilot Expansion



MHMC Advanced Primary Care Recognition – Coming mid 2013!

Office Systems	Clinical Outcomes	Patient Experience	Access to Care	Cost of Care
Level 1 or Higher on NCQA PPC-PCMH Medical Home Recognition	3 or more BTE Outcome Measures, 1 of which needs to be Depression	Recognition on CG-CAHPs Patient Experience Survey	Recognition on Access from Subset of CG-CAHPs survey questions	Recognition on Cost of Care Measures

Specific Levels of Recognition Needed In Each Component (i.e. Good-Better-Best) Will Be Determined through the PTE Process

MAINE Patient Centered Medical Home Pilot

www.mainequalitycounts.org

Maine Quality Counts
Better Health Care. Better Health.

Tools | Resources | Programs | About | Join | search...

Home ▸ Programs ▸ Patient Centered Medical Home

Programs

- Patient Centered Medical Home
- Aligning Forces for Quality
- QC Learning Community
- Behavioral Health Integration
- Pressure Ulcer Prevention
- Electronic Health Records to Improve Care
- Patient Family Leadership Team
- IHOC - Quality Counts for Kids
- Community Health Teams
- Transforming Care at the Bedside
- AF4Q Equity - ME Race, Ethnicity and Language Initiative

PCMH Links

- PCMH Home
- Assessing Practice Readiness
- Support for Practice Transformation
- Tools and Resources

Patient Centered Medical Home

Recognizing the essential role of primary care in our healthcare system, the Maine Quality Forum (MQF), *Quality Counts*, and the Maine Health Management Coalition are working together to lead the Maine Patient Centered Medical Home (PCMH) Pilot. Following an initial planning period, the group selected a group of 26 primary care practices in May 2009 to implement the PCMH model as a first step in ultimately achieving the goal of statewide implementation of a patient centered medical home model.

PCMH Learning Session 6: The Medical Home Run

PDF | | Print | | E-mail

Learning Session 6 for the Patient Centered Medical Home Pilot was held on Friday, June 3rd. The program focused on reducing avoidable health care costs. The day-long Session provided opportunities for the Pilot practice teams to learn more about steps they can take, in collaboration with their "medical neighbors", to address the important task of working together to reduce avoidable health care costs. One of the speakers, Arnold Milstein, based his talk on his 2008 blog entitled *Medical Homes—And Medical 'Home Runs'*. This posting can be found at: http://healthaffairs.org/blog/2008/09/10/medical-homes-and-medical-home-runs. Some of the presentation slides and handouts from this session are now available.

Read more... Add new comment

PCMH Learning Session 5 a Success!

PDF | | Print | | E-mail

The Maine Patient Centered Medical Home Pilot's

Payment Model & Financial Case for PCMH

PDF | | Print | | E-mail

The Case for Enhanced Payment for

Robert Wood Johnson Foundation

Karen Timberlake, JD

Director

Partnership for Healthcare Payment Reform

Partnership for Healthcare Payment Reform - Wisconsin

- What:
  - Bundled payment for **total knee replacement**
  - Shared savings model, transitions to global payment, for **diabetes** plus common co-morbid conditions

- How:
  - Multi-stakeholder, state-level effort convened by Wisconsin's all-payer claims data base, the Wisconsin Health Information Organization (WHIO)

  - Wisconsin Collaborative for Healthcare Quality (WCHQ), Wisconsin's Aligning Forces lead, is a WHIO founding organization and has been a key partner with PHPR

Partnership for Healthcare Payment Reform - Wisconsin

- How:
  - Built on existing coalitions, culture of innovation (WHIO, WCHQ, other transparency efforts)
    - Governance includes purchasers, providers, payers
  - Engaged expert facilitator to catalyze early planning
  - Recruited health system and health insurer senior leaders to chair planning groups
  - Consulted available models (IHA, PROMETHEUS)
  - Created small supporting infrastructure attached to WHIO

Partnership for Healthcare Payment Reform - Wisconsin

- What is happening currently:
  - Three Total Knee Replacement sites are live; two more this year
  - Two systems will launch Diabetes as part of Pioneer ACO
  - Gathering baseline cost/quality data; developing public reporting template
  - Ongoing technical assistance from payment reform pioneers as part of AF4Q

Partnership for Healthcare Payment Reform - Wisconsin

- What have we learned so far?
  - Payment reform is possible
  - Small projects develop competencies for bigger changes and are a tremendous diagnostic tool
  - Success requires:
    - Data
    - Understanding of true costs
    - Communication and trust among partners
    - Leadership commitment

Partnership for Healthcare Payment Reform - Wisconsin

- What have we learned so far?
  - Consultation with other communities, advice from experts has provided lessons learned, built confidence
  - Convener role remains critical
  - Greatest impact comes from integration with delivery redesign and transparency, not payment reform alone

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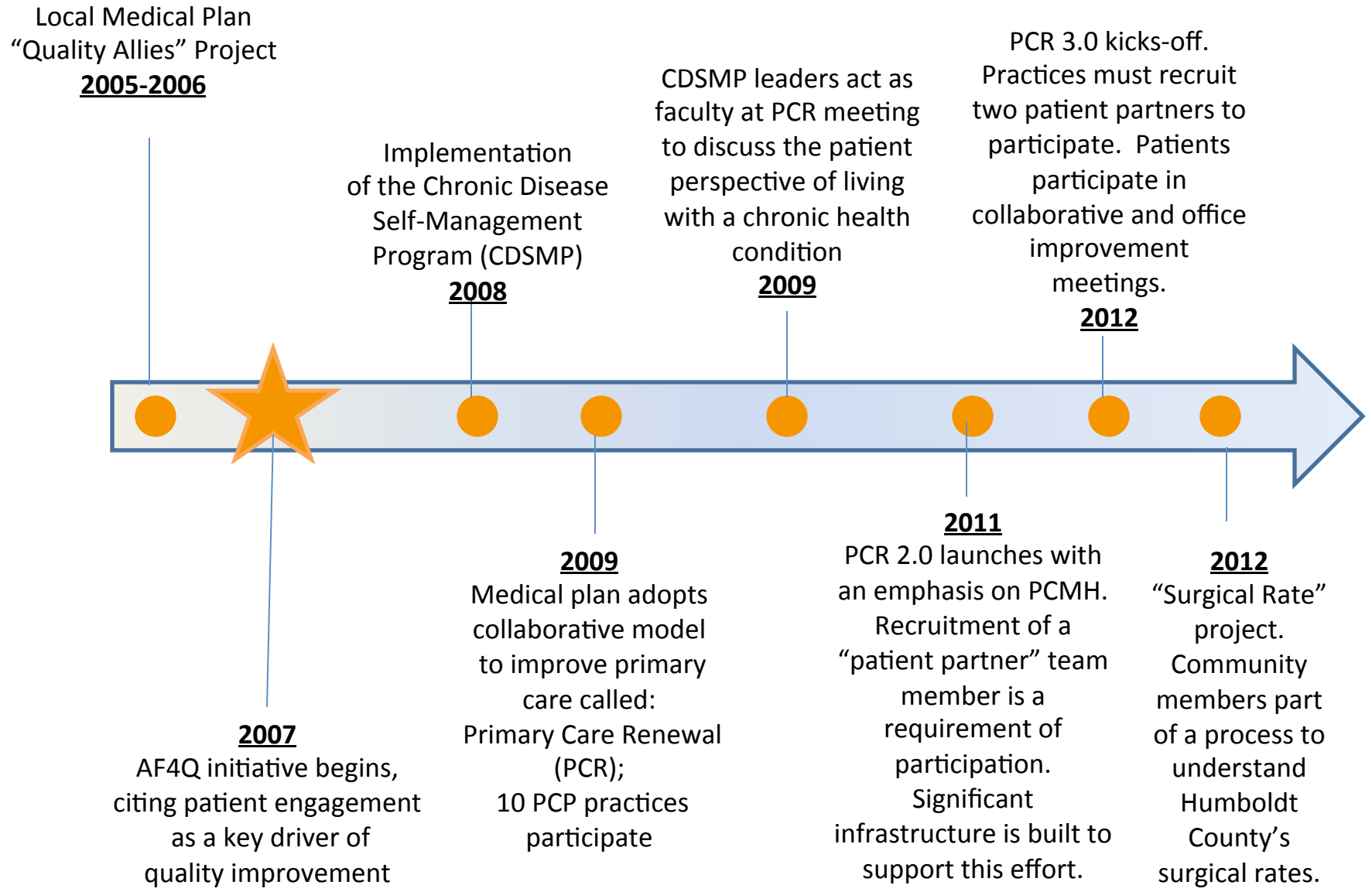
Betsy Stapleton

Lead Consumer Representative

Aligning Forces Humboldt

Humboldt County's Patient Engagement Journey



Patient Presentation

- 15-20 minutes patient presentation at each meeting
- Various formats: skit, Q&A, power-point
- Offers a broader consumer perspective on key subjects
- Includes tangible, implementable information, and recommendations for engaging patient partners further on the subject

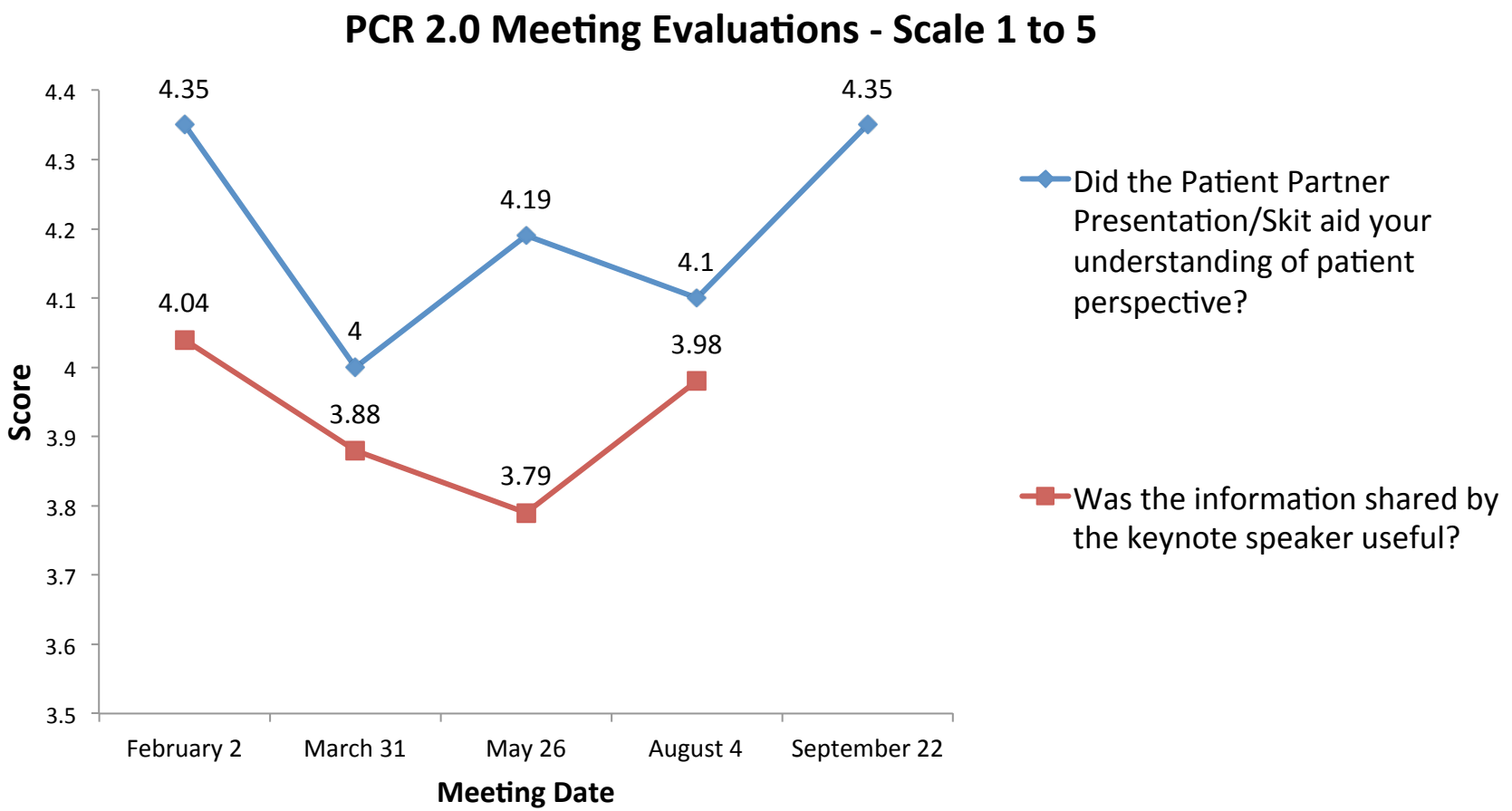
Team Meetings

- Patients attend one “practice improvement” meeting at their office each month.
- Some offices have standing agenda items specifically for their patient partners.
- Patients offer insight and work on projects specific to the practice.

Sample Projects:

- Practice brochure
- Direct to patient communications
- Testing patient portals
- System development

Effectiveness Of Patient Partner Presentations



Connect With RWJF & AF4Q

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www.rwjf.org/qualityequality • www.forces4quality.org

Transformation Has Begun

@rwjf_qualequal

@aligningforces

www.youtube.com/rwjfvideo