# ABCs of Practice Redesign

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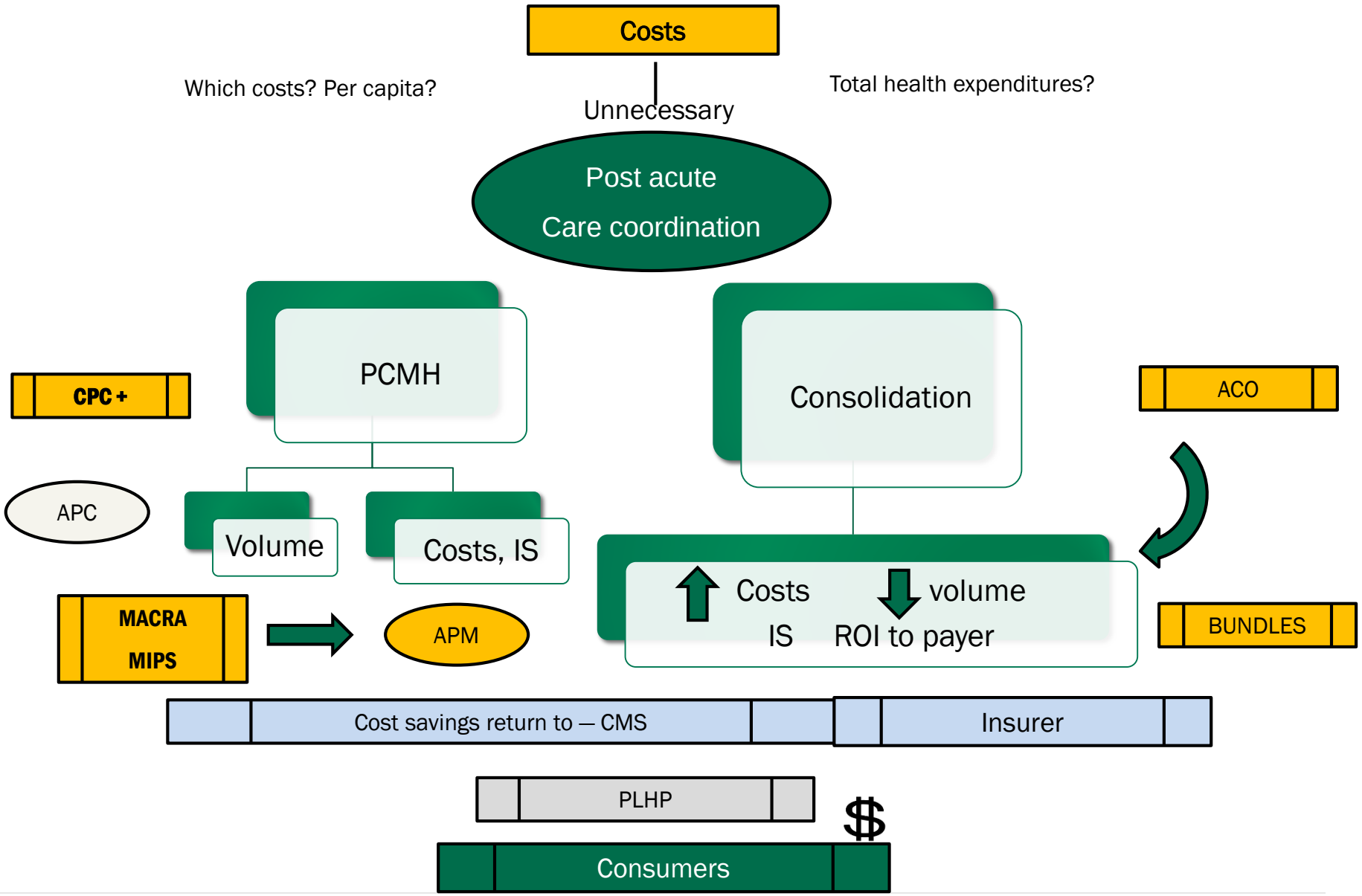
# Overview

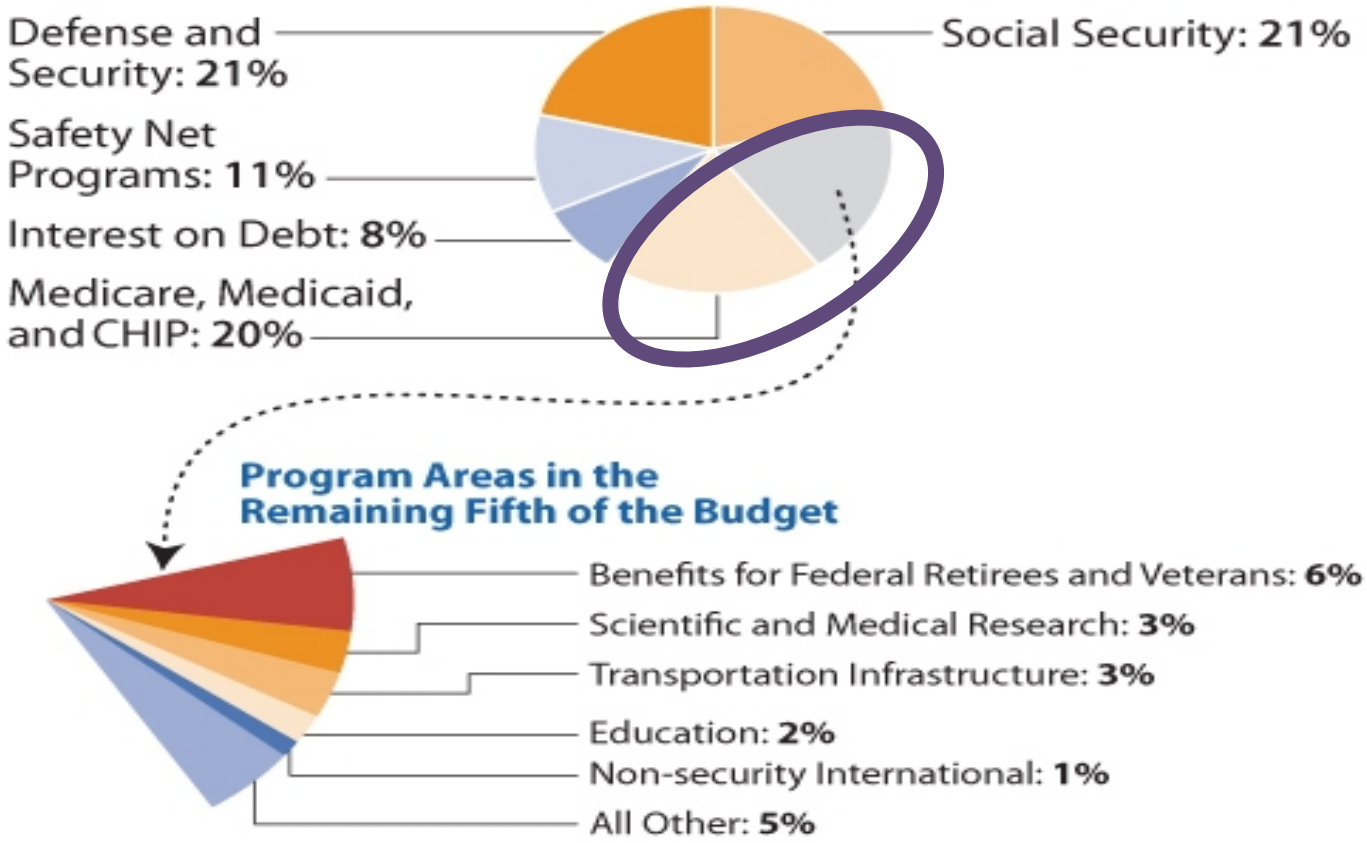
- Redesign considerations
- Why practice redesign
- Most common options
- Redesign considerations
- Q&A

# The Transitional Healthcare System



# Redesign Considerations

# $3.4 Trillion Out of $17.8 Trillion
# Not Much Room to Maneuver




Source: Congressional Budget Office
Note: Percentages may not total 100 due to rounding.

# Drivers of Costs: Healthcare System vs. Society

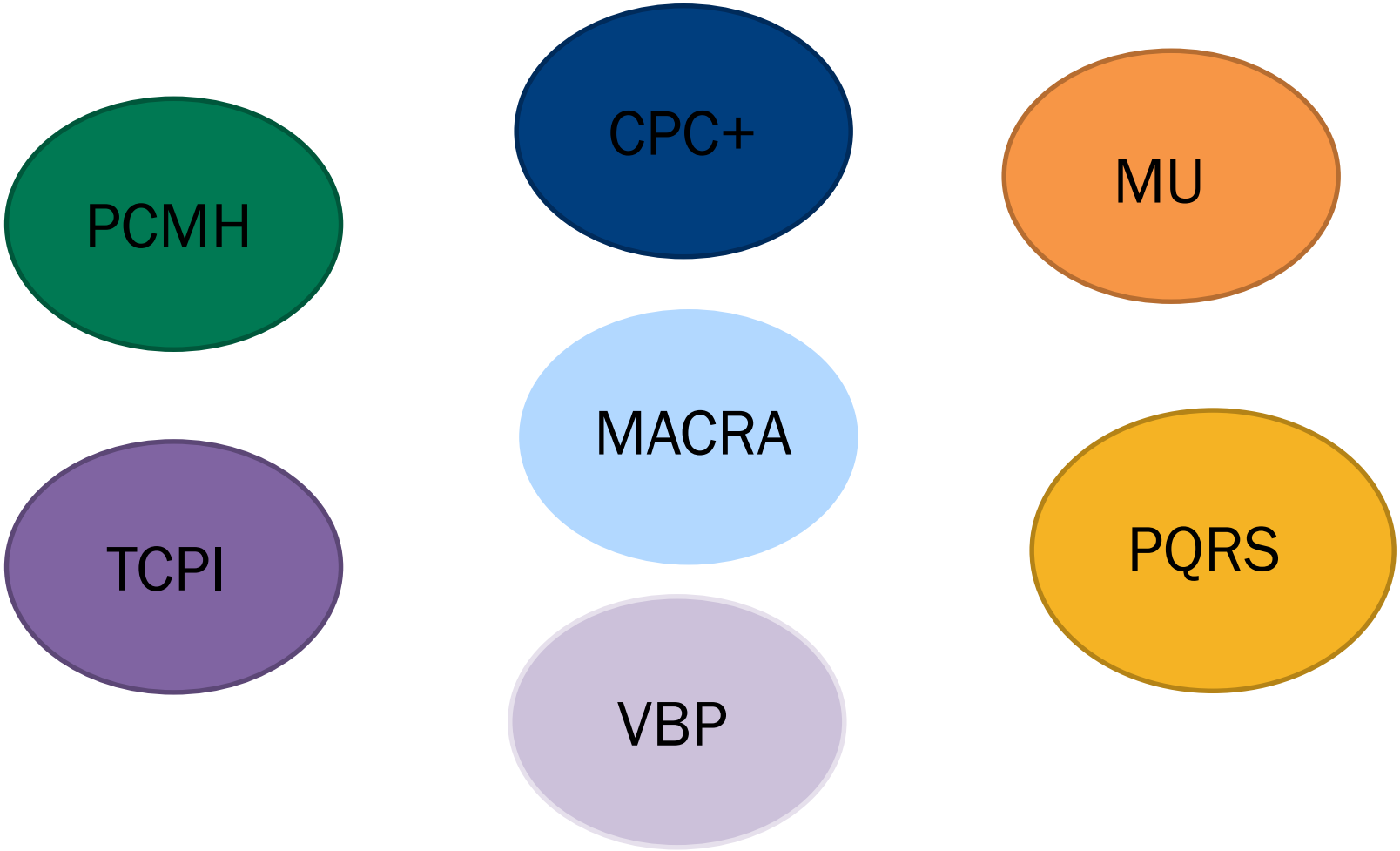
- Unwarranted variation in care
- Unnecessary tests and procedures
- Technology—HIM
- Administrative costs
- Lack of care coordination
- Workforce

- Aging of the population
- Rise in chronic disease
- Obesity
- Behavioral choices
- Patient expectations
- Relative wealth of U.S.
- Technology—innovation
- Pharmaceuticals

# Basic Redesign Options

- System redesign
  - Affiliations and mergers
- Payment redesign
    - Accountable Care Organizations
    - Bundled payments
    - Value-based payments
- Insurance redesign
- Practice redesign

# Alphabet Soup of Redesign



# Why Practice Redesign

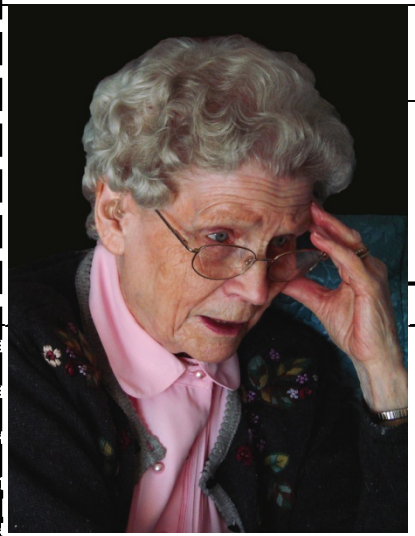
# Care Without Coordination

Meals/ Nutrition

Housing/ Home Support

Social Services

Nursing Home



Home Health Care

Transportation/ Mobility

Rx

Health Services

Family Care

Informal Care

Community
Church
Friends

Doctors
Hospitals
Clinics

Grandchildren
Children
Spouse

Financial Services

Health Insurance

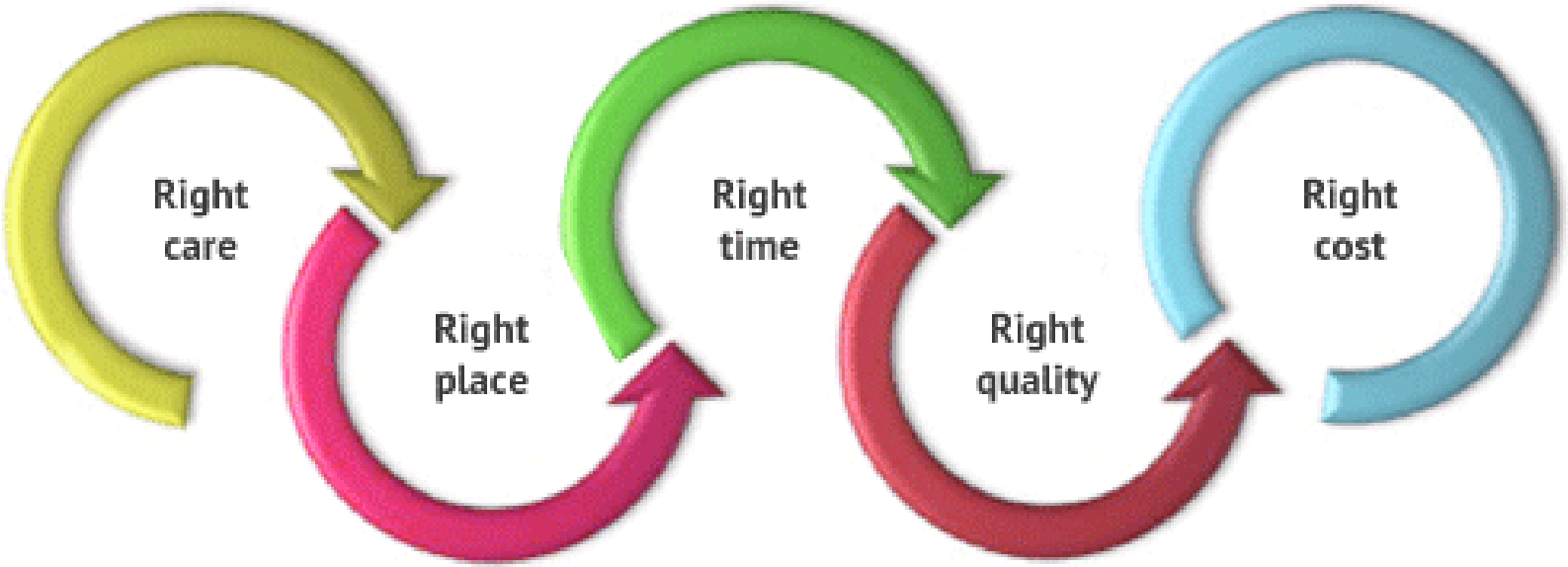
Medicare Part D

Medicaid
LTC Insurance

# Medical Neighborhood


Source: https://www.pcpcc.org/event/2014/08/2014-mid-atlantic-medical-neighborhood-forum

# Overarching Goal



# Impact of Coordinated Care

- More efficient use of services
  - Lab, imaging, ER, hospitalization
- Improved patient experience
  - Access, coordination, clinician collaboration, involvement in care
- Improved outcomes
  - CQI, evidence-based guidelines, medication management

# Practice Redesign Options

# Most Common Options

- Patient-Centered Medical Home (PCMH)
- Comprehensive Primary Care Plus (CPC+)
- Advanced Primary Care (APC)

# PCMH

https://youtu.be/btsGDHO_4IU

# Patient-Centered Medical Home (PCMH)

- Empowers the patient to be an active part of his/her healthcare team
- Physician-led team approach
  - Staff works to the highest capability of license/skill
- The right care, at the right place, at the right time

# Patient-Centered Planned Care

COLORADO CLINICAL GUIDELINES COLLABORATIVE


**Improved Outcomes**

- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

# Comprehensive Primary Care Plus (CPC+)

- National medical home model
- Multi-payer program
- 2 tracks with incrementally advanced care delivery requirements and payment options
- Available in Capital Region and Western New York

Source:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

# Comprehensive Primary Care Plus (CPC+)

*A new model for primary care in America*

Strengthening primary care is critical to promoting health and reducing overall health care costs. **CPC+**, the largest-ever initiative of its kind, is a five-year, multi-payer initiative to improve primary care in America.

## What is CPC+?

Practices will enter one of two program tracks. The track dictates the care delivery capabilities practices will develop and the payment structure they will receive.

### Comprehensive Care

- Patient Access
- Care Management and Coordination
- Patient Engagement and Population Health


Capabilities and Payment by Track

### Financial Support

- Care Management Payments
- Incentive Payments for Quality and Utilization
- Alternative to Fee-for-Service Payment Structure (in Track 2 only)

# CPC+

https://www.youtube.com/watch?v=DWUea_UD_Kw&feature=youtu.be&list=PLaV7m2-zFKpgXyFdYktqhUfgYcaGsSMPe

Through 2:05

# Advanced Primary Care (APC)

- New York State model of primary care delivery
- Designed to ensure:
  - Sustainable transformation
  - Improved clinical quality outcomes
  - Multi-payer engagement and incentive payments
  - Position practices for success with Value-Based Payment (VBP)

# Benefits of APC

- Multi-payer program
- Longer transformation timeline
  - Beneficial for smaller or less “ready” practices
- Focus on quality metrics
- Improve practices’ Value-Based Payment readiness

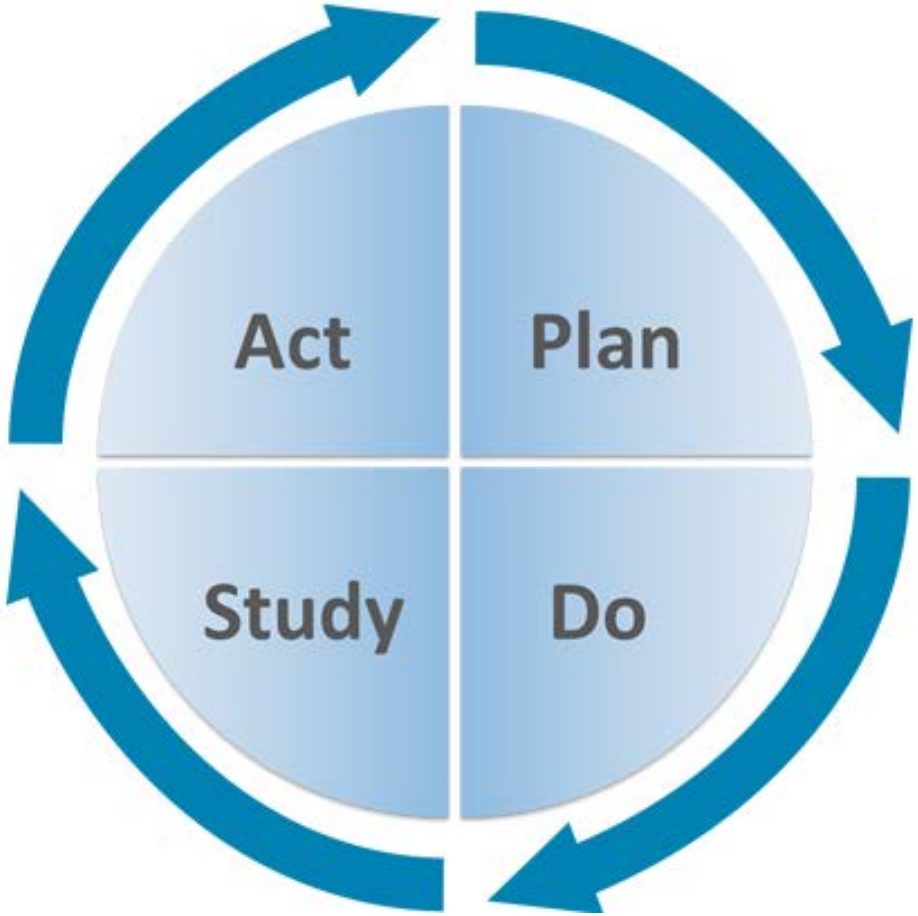
# Making Sense of the Options

# Lessons Learned from PCMH

- Culture
- People side of change
- Health Information Technology (HIT)
- Celebrate small wins
- Train, reinforce, coach
- Accountability

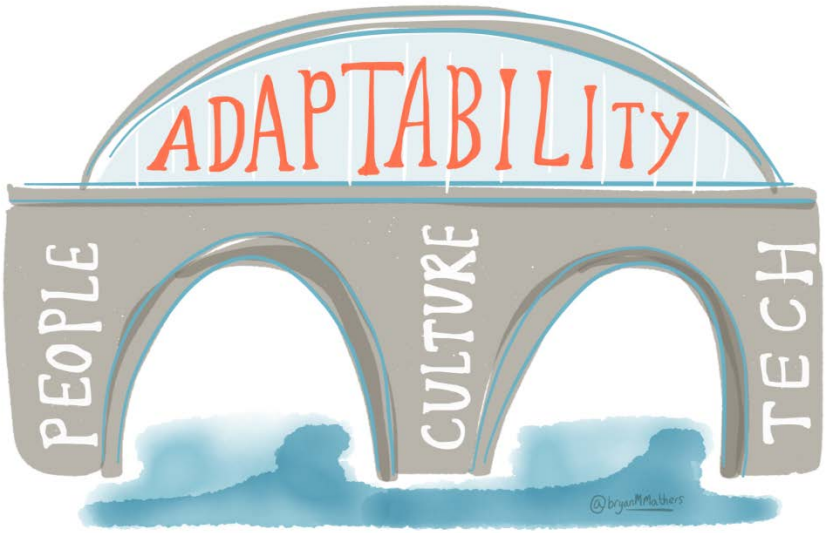
# Why is Culture Important?

# Improvement Cycles



# Sustainability = Adaptability

A willingness to adapt to the needs of patients and their family members, and to meet those needs in an objective, non-judgmental way




time for questions

# Questions

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