Primary Care Development Corporation

Brief Overview
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Chief Program Officer
Quality primary care is transformational and a cornerstone of healthy, thriving communities. PCDC catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.
A Quick History

• Founded in 1993 with $17m in seed money from the New York City Council
• PCDC became a lender of last resort for health centers that could not get loans from traditional banks
• Over time, PCDC expanded to provide training and technical assistance to help health centers and other providers meet growing regulation and participate in value based care initiatives.
• Currently PCDC offers:
  • training and technical assistance on providing health care services that are accessible, high-quality, and compassionate;
  • affordable capital to renovate and expand community health centers so that services are offered in settings that promote efficiency, dignity, and respect; and
  • advocacy to advance public policies that strengthen and sustain quality primary care.
PCDC Has Worked in 37 States through Jan. 2017
PCDC Made Investments in 10 States

PCDC made 67 investments in 10 states from FY2011-2016.

4 Investments in California
Ravenswood Family Health Center
Shasta Community Health Center
El Cajon Family Health Center
Healthright 360
Performance Improvement Worked in 33 States

PCDC was funded for 213 projects by organizations based in 33 states from FY2011-2016.

118 projects in New York State
PCDC’s Impact: 1993-2016

- **$848 million invested** in more than 129 primary care projects
- **980,000 patients** with improved access through primary care expansion
- **1.6 million square feet** transformed for primary care
- **8,200 jobs** created in low-income communities
- **7,000+ healthcare workers** trained in patient-centered care
- **250 practices** recognized as Patient-Centered Medical Homes
Policy/Advocacy Strengthened PCDC’s Positioning and Supported the Primary Care Sector

- Helped Primary Care by driving funding and transformation
  - Strengthened primary care in health system transformation (DSRIP, PCMH requirements and Primary Care Plans, preserving PCMH Medicaid incentives, NYS revolving fund)
- Helped secure business and funding to PCDC
  - NYS legislative grant, revolving fund, PCMH and DSRIP
- Policy leadership
  - Policy-focused convenings, policy reports, advocacy in NYS and DC
- Partnered
  - Co-founded Lenders Coalition for Community Health Centers; Executive member, Patient Centered Primary Care Collaborative, collaborate with NYS and national primary care organizations
Delivering Team-Based Chronic Care Management: Overcoming the Barriers

Findings, Recommendations and Resources from the Primary Care Development Corporation’s Integrated Care Planning Initiative
CASE STUDY

A 58 year old homeless man, with Insulin-dependent Diabetes Mellitus was referred to the THT Care Management Team by the Rescue Mission after living in the Rescue Mission emergency shelter for three years. Initial assessment by the Care Management Team, which consisted of a nurse case manager, a social worker and two community health workers, found that patient carried his Insulin and syringes in a cooler bag given to him by the Rescue Mission but was unable to draw up the Insulin and inject himself due to his inability to see. Since the patient was blind and could not self-medicate the social worker contacted his insurance company and was successful in getting him emergency placement in an assisted-living facility.
CASE STUDY

While in the assisted living facility he was found to have a sodium level of 119 and he was transported to the emergency department, admitted to the hospital and placed on fluid restriction until his sodium levels rose and then sent him back to the assisted living facility. Shortly thereafter his sodium level was 119 and again was sent to the emergency department who immediately returned him to the assisted living facility. Over this weekend the patient bounced between the emergency department and assisted living facility three times until he was admitted. Meanwhile, the assisted living facility states that they do not wish to accept him upon his discharge from the hospital because his medical conditions are too complex.
CASE STUDY

1. **What should be the next course of action for this patient?** *(check all that apply)*
   - Discharge him the next day
   - Place him on fluid restriction
   - Perform an urine osmolality
   - Order Thyroid Function Studies
   - Order an MRI of his head

2. **What should the Care Management Team do?** *(check all that apply)*
   - Contact the hospitalist to let him/her know that they are managing his care and to obtain updates on the patients progress and to be involved in discharge planning
   - Request that the hospitalist order an ophthalmology consult while in the hospital
   - Social worker should begin to look for alternative housing
   - Care team should work to transfer the patient to another hospital where he will receive better care.
Introduction

• The Integrated Care Planning Initiative commenced in 2014
• Funded by Altman Foundation and the Morton K. and Jane Blaustein Foundation to better address and overcome the challenges related to implementing and delivering Chronic Care Management in a primary care setting.
# Project Participants

<table>
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<th>Organization</th>
<th>Location</th>
<th>Funding for Care Management</th>
<th>Primary Care Delivery Setting</th>
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<tbody>
<tr>
<td>BrightPoint Health</td>
<td>New York City</td>
<td>New York State Health Homes</td>
<td>Federally Qualified Health Center (FQHC)</td>
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<tr>
<td>Community Healthcare Network</td>
<td>New York City</td>
<td>New York State Health Homes</td>
<td>FQHC</td>
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<tr>
<td>Institute for Family Health</td>
<td>New York City and Westchester County</td>
<td>New York State Health Homes ACO Grant funding for care management for patients who don’t qualify for Health Homes</td>
<td>FQHC with residency program</td>
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<tr>
<td>Mount Sinai Hospital System</td>
<td>New York City</td>
<td>New York State Health Homes Grant funding for care management for patients who don’t qualify for Health Homes</td>
<td>Internal medicine clinic with residency program.</td>
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<tr>
<td>Upstate Cerebral Palsy-Central New York Health Home</td>
<td>Utica, NY</td>
<td>New York State Health Homes</td>
<td>One FQHC and multiple behavioral health and social service provider sites.</td>
</tr>
</tbody>
</table>
Project Participants

• The organizations were:
  • Participating members of NYS Health Homes program
  • Were providing primary care, behavioral health and care management on site for Medicaid patients
  • Received a payment per patient per month (PMPM)
  • NCQA recognized PCMH with HER
  • Different organizational structures but challenged to deliver CCM as an integrated team.
Project Methodology

• Conducted and literature review
• Formed an expert advisory panel
• Provided learning sessions and technical assistance
• Collected data
Literature Review

• Conducted a review of 61 program evaluations, white papers, issue briefs and case studies on CCM in the US since 2006

• Sought to identify
  • Evidence supporting the effectiveness of CCM in the primary care setting
  • Evidence supporting the effectiveness of integrated care planning and a team-based care delivery approach
  • Successful models and approaches for delivering team-based CCM in a variety of settings
  • Common attributes and best practices of successful CCM programs
  • Challenges and solutions for the delivery of team-based CCM in primary care settings
Literature Review

• Common attributes and best practices of successful CCM programs include:
  • using quantitative and qualitative data to identify target populations who need services
  • comprehensively assessing patients’ risks and needs
  • care planning that includes goal setting and clear indication of an individual’s preferences and wishes and incorporates patients and families in care decisions
  • frequent care team contact
  • clear lines of communication between care team providers
  • a care team that works to create a common set of goals with which to direct patient care
  • facilitation of transitions out of the hospital
  • linkages to housing, behavioral health services, and other community resources
Limitations

- Few studies that focus specifically on models of Integrated Care Planning
- Challenges exist for researchers in that CCM covers a large array of patient types, conditions, practice settings and sizes, and differing payment models.
- Overall evidence of impact of CCM is limited which illustrates the need for more evaluation of existing programs and more examples of specific CCM models used in different types of settings that are the most effective in achieving the triple aim
Expert Advisory Panel

- Dave Chokshi, MD, MSc, New York City Health + Hospitals
- Rachel Davis, MPA, Center for Health Care Strategies
- Joslyn Levy, RN, MPH, Joslyn Levy & Associates
- Anne Meara, RN, MBA, NYU Langone Health System
- Kevin Muir, CAMBA
- Karen Nelson, MD, MPH, Maimonides Medical Center
- Alda Osinaga, MD, MPH, New York State Department of Health, Office of Health Insurance Programs
- Jorge Petit, MD, Quality Healthcare Solutions Group
- Rebecca Ramsay, BSN, MPH, CareOregon
- Maria Raven, MD, Department of Emergency Medicine, UC San Francisco
- Patricia Volland, MSW, Silberman School of Social Work at Hunter College
- Mathew Weissman, MD, MBA, Community Healthcare Network
Expert Advisory Panel

• Safety net provider organizations and leaders from medicine, nursing, behavioral health, housing, public policy and care management.
• Met 3 times between November 2014 and May 2016
• Provided insight into the systemic barriers organizations face in delivering team-based CCM
• Shared experiences addressing challenges in delivering team-based CCM in their own organizations
• Utilized the panels experiences in forming topics and approaches discussed in the learning communities
Project Structure

• The five participating organizations formed “change teams” which consisted of:
  • PCP
  • Care manager
  • Administrative representative
  • Behavioral health
  • Nursing
  • Care management supervisor

• PCDC created a roadmap for the change teams that summarized key drivers, related change ideas and best practices
Project Structure

• Road map elements include:
  • Obtain organizational commitment for team based chronic care management
    • Team based Chronic Care Management Staff Survey
    • Project Survey
  • Define care teams at the practice level
  • Engage and enroll eligible high-risk, high-need patients into care management
  • Enable clear, routine communication among care team members
  • Train care team members to function as a team
Learning Session and Technical Assistance

• The roadmap provided the foundation for the learning sessions and coaching calls

• Learning sessions consisted on lectures and other team based CCM related activities where change teams reported out to other team members, answered questions, shared challenges and success stories.

• Coaching calls provided an opportunity for the change teams to apply what they learned to address their challenges, develop solutions and test them between calls.

• Processes and strategies that were successful and/or produced the desired results became recommendations that were shared with senior leadership at each institution.
Data and Measurement

- Participating teams collected data during the project to track progress.
- Since each organization worked on different goals, not all quantitative process and outcome measures were tracked by all teams.
- Many teams had difficulty in collecting data and keeping up with reporting on processes developed and tested during the project.
- Measures tracked included:
  - Number of referrals from PCPs to care management teams.
  - Number of new referrals that result in enrollment in care management.
  - Number of cases discussed during case conferences.
Data and Measurement

• Outcome measures were difficult for all teams to track
• Change in patient health status was challenging for care managers to report as they were not doing this in their programs
• Patient activation and patient engagement metric reporting was encouraged by PCDC but the organizations were not able to track this data even though they agreed that it would be helpful
• Lack of manpower, inadequate HIT systems, unsure of what clinical metrics to track with complex patients and what number of metrics would be manageable
Data and Measurement

• Exit interview common themes included:
  • Enhance inter-departmental communication
  • PCPs and staff from other departments have an better understanding of how they contribute to patient care
  • PCPs and staff feel less isolated in their roles and know who they can contact
  • Leadership has many misconceptions about HIPAA and thus were hesitant to share patient information across providers even if consent forms were provided
  • Patients reported to the care managers that they felt their care was more coordinated
  • Having patient information located in multiple systems across departments within and across organizations was a significant barrier to effective collaboration
Key Findings

• Interdisciplinary case conferencing is unfamiliar but found to be very valuable
• Engaging PCP’s in CCM increased enrollment in CCM
• Most EHRs do not currently support team-based care
• A coordinated response to critical patient events requires clear direction from leadership and defined interdisciplinary teams
Organizational and Practice Recommendations

• Empanel patients based on interdisciplinary teams
• Establish protected time and payment for regular case conferencing involving all care team members
• Embed care managers, conduct warm hand-offs and train practitioners to increase CCM enrollment
• Establish coordinated, integrated follow-up after critical events/unplanned events
Policy Recommendations

• Payment must support team based care
• States should recommend that practitioners select EHRs that are fully functional for all health care and care management services, as well as fully interoperable with other systems
• States and health plans should use algorithms that identify patient loyalty and utilization patterns to assign patients to existing PCPs and care management services
• Leverage federal HITECH matching funds to expand primary care and behavioral health integration
• Promote integrated care for patients with a substance abuse disorder
• Enable billing for same day physical and behavioral health visits at FQHCs
• Provide clearer guidance regarding confidentiality laws to facilitate data sharing
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THANK YOU