Delaware Practice Transformation

As part of DE's SIM plan, practice transformation efforts have sought to provide practices with the resources they need to provide convenient, effective, well-coordinated care that supports the Triple Aim. The practice transformation program was available to all primary care practices in Delaware. The curriculum was tailored to the unique needs of each participant to account for the diversity in practice progress toward various coordinated care models. The practice transformation program began enrolling practices in September 2016 and coaching, offered through one of four vendors, ended in April 2018.

Participants

In total, 112 unique practices have participated in the program, and 109 remained enrolled for at least 6 months. Over 350 providers, including about 250 physicians and 100 mid-levels participated through these practices. There was some attrition over time in the program. In April 2018, 84 practice sites, remained enrolled in practice transformation encompassing 270 unique providers (195 physicians and 76 mid-levels).

Geographic clustering is evident among enrolled practices and is reflective of the location of primary care practices across Delaware. In April 2018, 57% of all enrolled sites are in New Castle County; Kent and Sussex counties account for 17% and 26% of enrolled sites, respectively. Participants were largely located in metropolitan areas; Wilmington, Newark, Dover, and Milford comprised 64% of enrolled practice sites.

Milestones

Participants were expected to make progress toward nine practice transformation milestones recommended by the Delaware Center for Health Innovation (DHCI). These milestones are representative of the elements of NCQA's PCMH recognition. Additionally, DCHI defined 3-4 relevant sub-criteria for each milestone to assist practices, technical assistance vendors (site coaches), and DCHI to more accurately identify specific areas of practice transformation progress. (*see attachment of full list of milestones and sub-criteria)*

Through an initial process of self-assessment, guided by the vendors' site coaches, the practices were scored on each milestone and the sub criteria in order to document a baseline for each practice, and to reflect the status of transformation across the cohort of practices. The scoring is as follows:

1- Practice has not yet started the associated activities
2- Practice is in the process of implementing, or partially operating, the associated activities
3- Practice is fully performing the associated activities

As assessment of NCQA PCMH recognition status was completed at the beginning of the practice transformation coaching period in 2016. Just over 10% of the total participating sites were recognized at either level 2 or 3. Data from the vendors is incomplete regarding the number of sites who formally submitted or obtained PCMH during the coaching process. Only one vendor reporting this information, and it has not been validated. This question was asked of the practices in the follow up survey in 2018. Less than 30% of the sites participating in April 2018 responded, and of those, none had submitted an application during the coaching period for various reasons indicated in the survey.

Practice Name	Site Name	Recognition Level
Family Practice Center	Family Practice Center	NCQA Level 2
Milford Medical Associates PA	Milford Medical Associates Mullet Run Street	NCQA Level 3
Milford Medical Associates PA	Milford Medical Associates Federal Street	NCQA Level 3
Family Medicine of Greenhill	Family Medicine of Greenhill	NCQA Level 3
La Red Health Center	La Red Health Center Georgetown	NCQA Level 3
La Red Health Center	La Red Health Center Seaford	NCQA Level 3
Nanticoke Physician Group	Nanticoke Health Pavilion Bridgeville	NCQA Level 3
Nanticoke Physician Group	Nanticoke Health Pavilion Seaford	NCQA Level 3
Nanticoke Physician Group	Nanticoke Health Pavilion Laurel	NCQA Level 3
Nanticoke Physician Group	Nanticoke Health Pavilion Georgetown	NCQA Level 3
Christiana Care Health Partners	Wilmington Adult Medicine	NCQA Level 2

Total Practice Sites with NCQA Certification	11
Total Practice Sites	108
Share of Practice Sites with NCQA Certification	10.2%

The TA site coaches met monthly with a majority of the sites in their cohort throughout the contract period and adjusted the score for any progress made toward meeting the milestone or the sub criteria.

A total of 112 practices participated in the TA project, while 84 were still participating in April 2018. The 28 sites that terminated the TA early due to a variety of reaching including: reaching all milestones as reported by one TA vendor (20 practices), changes in practice ownership, and competing priorities that limited the time and resources available for PT, for instance one practice was working to expand to a new location. **In total, 95 practices, or 85% of participants, completed between 16 and 20 months of TA with the average length of participation being 17.5 months.** Note that 2 vendors ceased TA prior to the May 2018 project end date. One vendor reported that the large majority of their assigned sites had attained their milestones, so they determined their TA was completed 5 months early. Another vendor ceased TA approx. 2 months early due to staffing issues. The remaining 2 vendors completed TA coaching through April 2018.

The following section describes progress made toward the nine milestones and their 3-4 sub criteria for each milestone (totally 28 separate elements of evaluation). Limitations of this reporting are listed below, and should be taken into considerations when drawing conclusions on the impact of this practice transformation project:

1. Baseline assessment, monthly progress and the final evaluation were scored and (self) reported by each TA vendor. There was no external validation of any of the reporting or scoring and no inter-rater reliability.
2. There was no further clarification on defining scores 1, 2,3 other than the brief description to guide the 4 vendors in consistent interpretation of progress.
3. Inconsistencies or contradictions are noted- such as: sites scoring a 3 on certain milestones, yet 1-2 on related milestones are inconsistent or need further clarifications.

4. There is significant variation among scores from the four TA vendors in the baseline, monthly and final scoring. This variation could be multi-factorial based on the inconsistency in the TA design including: the practices were not assigned randomly, coaching/scoring was not necessarily delivered in a consistent manner and the amount of TA that practices received varied greatly.
5. The scores came from individual practices, some of which belonged to larger practices, health systems or ACOs which could over represent the cohort compared to the scores from small single provider practices.

Given these limitations in the data, the cohort of practices appeared to show progress over time in meeting milestones and their sub criteria. At the time of the baseline assessment in 2016, practices met an average of 4 of the 9 milestones. By the completion of the project in 2018, practices met an average of 7.4 milestones.

Four milestones had the highest passing rate, with over 90% of participating practices meeting the milestone:

- Milestone 4 (Supply voice-to-voice coverage to panel members 24/7) - 96.4%
- Milestone 1 (Identify 5% of the panel that is at the highest risk and highest priority for care coordination),
- Milestone 2 (Provide same-day appointments and/or extended access to care)
- Milestone 6 (Document plan to reduce emergency room utilization).

Practices performed the worst on these two milestones:

- Milestone 8 (Implement a multi-disciplinary team working with highest-risk patients to develop care plans) -66.7%
- Milestone 9 (Document plan for patients with behavioral health care needs) 52.4%

Table x: Share of Practices who have Passed PT Milestones, April 2018

Milestone 1: Identify 5% of the panel that is at the highest risk and highest priority for care coordination	90.5%
Milestone 2: Provide same-day appointments and/or extended access to care	92.9%
Milestone 3: Implement a process of following-up after patient hospital discharge	86.9%
Milestone 4: Supply voice-to-voice coverage to panel members 24/7	96.4%
Milestone 5: Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan	82.1%
Milestone 6: Document plan to reduce emergency room utilization	91.7%
Milestone 7: Implement the process of contacting patients who did not receive appropriate preventive care	84.5%
Milestone 8: Implement a multi-disciplinary team working with highest-risk patients to develop care plans	66.7%
Milestone 9: Document plan for patients with behavioral health care needs	52.4%

Along with this quantitative assessment, the TA vendors reported the successes and challenges of various practices in a monthly summary of TA activities. *A sampling of these comments is included in the appendix.* Note that this descriptive section of the report was not designed to be a scientifically rigorous qualitative review, but it is representative of typical challenges faced by primary care providers working toward practice transformation. The variety of comments were generally consistent across the four TA vendors. Challenges included: issues with data collection and data sharing, inadequate resources of time and staff in order to carry out the tasks, barriers related to EHR adoption and staff turnover.

Participating Practice Experience

HCC conducted a survey assessing the practice transformation experience among participants who had finished the program in April 2018 and received responses from 25 participants, or 29% of participating practices. Practices were contacted multiple times by email and phone over a 2-month period to encourage completion of the survey. *A copy of the survey questions is included in the appendix*.

Nearly two-thirds of respondents rated their practice transformation experience as excellent or very good. The majority (60%) of respondents found the practice transformation coaching very important to their ability to enact changes, and the remainder found that while coaching provided some support, they made most their practice transformation changes on their own.

The most common barrier to practice transformation, cited by 60% of respondents, was the lack of adequate staff time for calls and meetings. Other common barriers included challenges with adequate staffing, buy-in from providers, and technology/EHR challenges.

Three-quarters of respondents did not have PCMH recognition prior to beginning practice transformation and most did not plan to apply for PCMH certification. The PCMH certification process was considered too expensive and resource intensive to justify the investment. Only 40% of practices reported a payer contract that directly incentive PCMH certification. Much more common, 80% of respondents reported contracts that provide incentive for quality metrics, patient satisfaction surveys, or closing specific care gaps.

One-third of respondents were already familiar with and using DHIN, over half of respondents came out of practice transformation process with a better understanding of DHIN and plans to start using it. Despite this familiarity with DHIN, very few respondents had reviewed their Delaware Common Scorecard.

Respondents recommended additional coaching be focused on a wide range of topics. These included: assistance with EHRs or EHR training, help with PCMH certification, behavioral health integration, staff development, operating in the changing landscape of value-based payment models (including MIPS), and using expertise and best practices to help set up plans to reach milestones.

Nearly 90% of respondents said they would recommend the coaching to others or enroll in additional coaching if it was offered. Those that would not recommend coaching found their experience to be too time-consuming to justify the benefit received. One respondent recommended that rather than paying a consultant to coach practices, the funding from CMS should be used for practice-level improvement akin to CPC+.

Attachment 1: Practice Transformation Milestones

Milestone 1: Identify 5% of the panel that is at the highest risk and highest priority for care coordination

1. Practice has a systematic process and documented criteria for identifying highest-risk patients as it best suits the unique practice needs and goals (NCQA PCMH)
2. Practice has established documented data sources and data-handling processes to identify the highest-risk patients. Potential data sources include claims information, EMRs, practice management systems, staff recommendations, etc.
3. Practice successfully updates its documented list of the top 5% highest-risk patients at least semi-annually (NCQA PCMH)

Milestone 2: Provide same-day appointments and/or extended access to care

1. Practice has a documented process and defined standards for reserving time for same-day appointments and appointments outside its typical daytime schedule (NCQA PCMH)
2. Practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the instructions for obtaining care and clinical advice during office hours and when the office is closed (NCQH PCMH)
3. Practice collects patient experience and satisfaction data on access to care and uses these data to develop an access improvement plan (CMS)

Milestone 3: Implement a process of following-up after patient hospital discharge

1. Practice shares clinical information with admitting hospitals and EDs (NCQA PCMH)
2. Practice proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit (NCQA PCMH)
3. Practice offers or refers patients to structured health education programs, such as group classes and peer support (NCQA PCMH)

Milestone 4: Supply voice-to-voice coverage to panel members 24/7 (e.g., patient can speak with a licensed health professional at any time)

1. Practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times (NCQA PCMH)
2. The on-call provider has continuous computer access to patient records through remote log-on to practice's EMR (NCQA PCMH)
3. Practice regularly assesses its performance on (NCQA PCMH):
    a. Providing continuity of medical record information for care and advice when office is closed
    b. Providing timely clinical advice by telephone
    c. Providing timely clinical advice using a secure, interactive electronic system

Milestone 5: Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan

1. Practice has identified practice-level organizational structure and staff leading and sustaining team-based care (NCQA PCMH)
2. Practice has defined its approach for sourcing care coordination (e.g., through vendor support or hiring a care coordinator)
3. Practice has documented its approach to implement team-based care and develop care plans for high-risk patients

Milestone 6: Document plan to reduce emergency room overutilization

1. Practice provides patients with materials for obtaining care and clinical advice during office hours and when the office is closed (NCQA PCMH)
2. Practice proactively identifies patients with unplanned admissions and ER visits (NCQA PCMH)
3. Practice proactively contacts patients / families for follow-up care after discharge from hospital / ER within an appropriate period (NCQA PCMH)

Milestone 7: Implement the process of contacting patients who did not receive appropriate preventive care

1. Practice uses panel support tools (registry functionality) to identify services due (CMS)
2. At least annually, practice proactively reminds patients or their families/caregivers of needed care (using evidence-based guidelines) for preventive care services, immunizations, and patients not recently seen by Practice (NCQA PCMH)
3. Practice uses reminders and outreach (e.g., phone calls, emails, postcards, patient portals, template letters, etc.) to alert and educate patients about services due (CMS)

Milestone 8: Implement a multi-disciplinary team working with highest-risk patients to develop care plans

1. The practice monitors the risk-stratification method and refines as necessary to improve accuracy of risk status identification (CMS)
2. Practice trains and assigns members of the care team to coordinate care for individual patients (NCQA PCMH)
3. Practice trains and assigns members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change (NCQA PCMH)

Milestone 9: Document plan for patients with behavioral health care needs

1. Practice has a process for informing patients / families about the role of the medical home and gives patients/families materials describing the scope of services available within Practice, including how behavioral health needs are addressed (NCQA PCMH)
2. Practice ensures regular communication and coordinated workflows between primary care clinicians and behavioral health clinicians (CMS)
3. Practice uses a registry or certified health information technology functionality to support active care management and outreach to patients (CMS)

Attachment 2: Qualitative Summary- sampling of comments from TA vendors collected during site coaching visits

- Some practices state that they have challenges with communication in the practice, they are working to address this by working to identify the barriers to communication and how best to address them. [October 2017]
- Another challenge, as described by a pediatrics practice, is capturing accurate data. They recently ran reports, aiming to identify a roster of patients with a specific diagnosis, they found that the data does not always match up as expected. Information is documented and updated in the problem list of their patients' charts and when they try to run reports, they sometimes get conflicting results. The practice is working to standardize their criteria for running the reports to improve data accuracy. [October 2017]
- Several vendors continue to report struggles with practices' EHR systems. For example, vendor A noted that several practices are still having to verify EHR data accuracy using manual methods, which is delaying PT transformation efforts. [December 2017]
- Vendor B stated that several of their enrolled practices are having difficulty getting patients to complete surveys and provide feedback on areas for practice improvement. The vendor is working with practices to encourage patients to complete surveys and provide constructive criticism. [December 2017]
- Vendor B noted the lack of community Behavioral Health providers, especially in Sussex County, as a barrier slowing milestone achievement among enrolled practices. One enrolled practice is actively working on building relationships with behavioral resources in the Sussex County community. [December 2017]
- Vendor C is still attempting to engage more with a larger, multi-site group. [same comment December 2017 – March 2018]
- Vendor A summarized its current obstacles to PT activities: staffing, maintaining buy-in from the entire practice, change fatigue, Medicare reporting requirements, maintaining priorities, and information overload. [January 2018]
- Vendor C noted that time has been a barrier for multiple practices. Practices are often involved in many activities and it is difficult to find the time and resources to focus on Milestone progress. [February 2018]
- Vendor B stated that one enrolled practice (Family Practice) recently hired additional staff and can now engage more in PT activities. [March 2018]
- Vendor D stated that practices continue to struggle with staffing and turnover. [April 2018]
- Vendor D noted that PT progress was noticeably slower during the month due to holidays and increased number of sick patients visiting the practices. The vendor has reduced its number of interruptions to any practices signaling that they are currently overwhelmed. [December 2017].
- One practice is working to establish an informal working relationship with its most-frequently used behavioral health provider. This practice is also determining if its EHR can support active care management and patient outreach. [January 2018]
- Vendor B underscored the importance of leadership engagement on practices' ability to achieve PT progress. [January 2018]
- Vendor A noted that one of its previously-enrolled practices closed its practice effective 12/31/17; providers from this practice joined another practice enrolled with the same vendor.

Thus, the number of enrolled practices for this vendor decreased by one while its number of enrolled providers remained constant. [January 2018]

Attachment 3: Survey Questions

1. Practice Name
2. Name/Address of Site (please complete all fields)
3. Your Name
4. Your Role at the Practice
5. How many months did your practice participate in PT coaching?
6. Please choose the name of the PT vendor you worked with
    a. MSDMedNet
    b. MedAllies
    c. NJAFP
    d. Remedy
    e. Other (please specify)
7. What role did PT coaching play in making significant practice transformation?
    a. Coaching was very important and it's unlikely we would have made changes without help
    b. Coaching provided some support; we made most of our practice transformation changes on our own
    c. Coaching had no impact
    d. Other (please specify)
8. Did your practice ownership have any significant changes during this time period? Such as: (Check all that apply)
    a. Changing from an independent practice to joining an ACO
    b. Leaving an ACO
    c. Merging with another practice or provider/medical group
    d. There were no significant changes during this time period
    e. Other (please specify)
9. What barriers did you face when trying to make practice transformation? (Check all that apply)
    a. Difficulty getting provider buy-in
    b. Difficulty getting leadership buy-in
    c. Staffing turnover
    d. Lack of an adequate skilled workforce
    e. Lack of adequate time for meetings, calls, etc.
    f. Lack of funding for specific programs or training
    g. Other (please specify)
10. Several organizations provide certification or recognition for PCMH. Did your practice have PCMH recognition or certification such as NCQA, URAC or JCAHO prior to the beginning of the PT coaching? Was your practice already certified or did you submit prior to the beginning of the PT coaching?
    a. Yes
    b. No

11. Which of these organizations are you recognized/certified by or plan to become recognized/certified by? (Check all that apply)
    a. NCQA
    b. URAC
    c. JCAHO
    d. None
    e. Other (please specify)
12. If you were not certified prior to the beginning of coaching, did your practice apply or will your practice apply for PCMH recognition during the PT coaching?
    a. Yes
    b. No
    c. Not Applicable
13. If no, will you be submitting for PCMH recognition by the end of 2018?
    a. Yes
    b. No
    c. Not Applicable
14. If you have not submitted, and do not plan to submit by the end of 2018, what are the barriers to submission? (Check all that apply)
    a. Too much paperwork and too time consuming
    b. Would need to hire more staff support to do the application
    c. We don't see the value or the return on investment of resources
    d. Too expensive
    e. Not Applicable
    f. Other (please specify)
15. Are any of your current contracts with payers offering incentives for PCMH recognition?
    a. Yes
    b. No
16. If yes, what form do the PCMH incentives have? (Check all that apply)
    a. A PMPM payment related to recognition
    b. Enhanced payment for quality targets
    c. Support for PCMH staffing (care managers or care coordinators)
    d. Not Applicable
    e. Other (please specify)
17. Are any of your current contracts providing an incentive for achieving thresholds on specific quality metrics, patient satisfaction surveys, or closing specific care gaps?
    a. Yes
    b. No
18. Did the practice transformation process assist with your use of DHIN or understanding of how DHIN can be helpful to your practice?
    a. Yes, we have a better understanding of DHIN and plan to learn more, or to start using it
    b. No, we are unclear on how DHIN can be helpful to our practice
    c. Other (please specify)

19. DHIN maintains the Delaware Common Scorecard metrics for each practice. Have you ever reviewed your practices' scores on the Common Scorecard metrics?
    a. Yes, I am aware of the scorecard and we have reviewed our scores
    b. No, I am aware of the scorecard, but I have never checked our scores
    c. No, I did not know about the scorecard
20. Has coaching and related work flow changes led to better morale or less sense of burnout?
    a. Yes
    b. No
21. Overall, how would you rate your practice transformation experience?
    a. Excellent
    b. Very Good
    c. Good
    d. Poor
22. If similar coaching were available, would you recommend this to another practice, or would you enroll yourself?
    a. Yes
    b. No
23. What would you recommend the focus of the coaching be?
24. Why would you not recommend or participate in further coaching?
25. Have you received information on the current opportunity to participate in the Behavioral Health Integration coaching?
    a. Yes
    b. No
26. Did you enroll?
    a. Yes
    b. No
27. Why did you choose not to enroll?
    a. Did not hear about it
    b. Interested, but not a good time for our practice to participate
    c. Not interested
    d. Not Applicable
    e. Other (please specify)
28. The ten metrics listed below were goals for the PT program and the coaches, and they reflect elements of a patient centered medical home. Please indicate how PT coaching impacted your progress toward meeting these goals- whether the goal was already met prior to coaching, or if you met the goal during coaching or if the goal is not met, but you're still working on it or lastly if this is not a goal for your practice.
    a. Proactively identify high-risk and high-needs patients
    b. Improve our access to care and/or same day appointments
    c. Improve our process to follow up after hospital discharge or ED visit
    d. Improve our ability to create a care plan for our high-risk patients
    e. Create a plan to decrease ED utilization

f. Proactively identify and contact patients who need preventative services
g. Implement a multi-disciplinary care team to create a care plan for high-risk patients
h. Develop better communication between primary care and behavioral health providers
i. Use a registry or certified HIT technology to support active care management or outreach to patients

29. Please use this space to provide any additional comments on your PT experience.