



**ACGIM 2007 Meeting
Experiences in GME Redesign:
Integrating “Next Generation” Patient-
Centered and Coordinated Care
Models into GME Redesign**

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Objectives

- Posit that clinical best practice models to include patient-centered and coordinated care are necessary for GME redesign.
- How might GME redesign be supported by these models?
- What fiscal support is required to redesign GME in the context of these best practice models?
- How will the current reimbursement model need to change so as to support patient-centered and coordinated care?

Background

- Crisis in primary care and primary care physicians supply the bulk of care
- Chronic disease management (CDM) is looming
- CDM strategy improves quality, supports primary care physicians and patients, and is applicable in a diverse range of clinical settings
- CDM address multiple objectives by allocating dedicated health care collaborators to work directly with patients at the point of care
- Managing the daunting needs of patients with multiple co-morbid chronic conditions is perhaps the greatest challenge confronting primary care physicians

The impending collapse of primary care medicine and its implications for the state of the nation's health care: A report from the American College of Physicians. January 30, 2006. Available at: http://www.acponline.org/hpp/statehc06_1.pdf Accessed November, 10, 2007.

Bodenheimer T. Primary care—will it survive? *N Engl J Med.* 2006;355(9):861-864.



Our Journey to enhance Patient-Centered Coordinated Care and GME Redesign



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AAMC Initiatives:
Academic Chronic Care Collaborative
RWJF ACT (Achieving Competency Today) II, III, Transitions
Macy Foundation CICE (Chronic Illness Care Education)
IHI Health Improvement Collaborative



← *Quality Improvement/Safety/Patient-Centered Themes*

ACGME EIP (Education Innovation Project)

Healthcare Delivery System (HDS) & Chronic Disease Management (CDM): New Agendas

Chronic Care Model (multidisciplinary care)	Self-management	Care-coordination (Care Transition)	Palliative Care
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Domains affected by HDS CDM Agendas:

Patient Care	GME/UME	Clinical Research	Leadership/ Administration
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Chronic Care Model Implemented in Community Center Collaboratives

- Study of community health centers participating in quality-improvement collaboratives (the Health Disparities Collaboratives sponsored by the HRSA) for the care of patients with diabetes, asthma, or hypertension
- The intervention centers had significant improvements in the measures of prevention and screening to include:
 - a 21% increase in foot examinations for patients with diabetes,
 - a 14% increase in the use of antiinflammatory medication for asthma, and
 - a 16% increase in the assessment of glycated hemoglobin.

SGIM Coordinated Care Model & ACP Patient-centered Medical Home

- Ongoing relationship with a personal physician
- Multidisciplinary medical team responsible for care
- Coordinated care for all stages of a person's life
- Quality and safety priority
- Enhanced access to care
- Payments based upon added value for care of patients with medical homes
- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PC-MH

PATIENT-CENTERED MEDICAL HOME

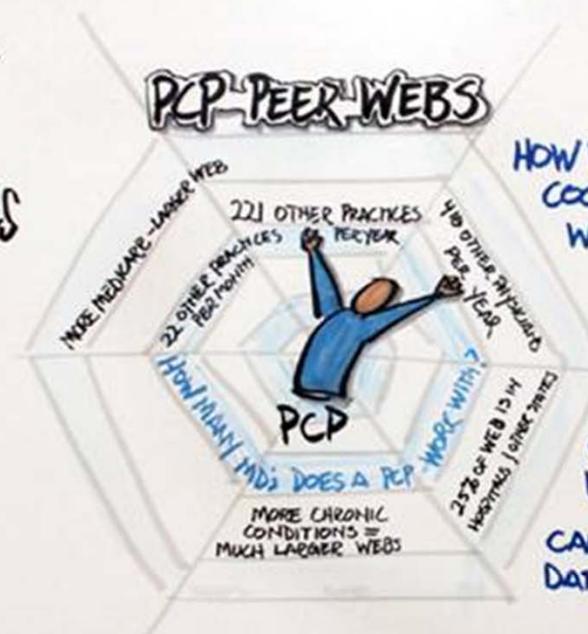
WHY? MORE COMPLEX PATIENTS
BETTER OUTCOMES
GREATER EFFICIENCY

PRINCIPLES
PERSONAL PHYSICIAN
PHYSICIAN-DIRECTED PRACTICE
WHOLE PERSON
COORDINATION / INTEGRATION
QUALITY / SAFETY
ACCESS TO CARE
PAYMENT



HELPS PATIENTS CARE FOR SELVES
EFFICIENT USE OF COMMUNITY RESOURCES

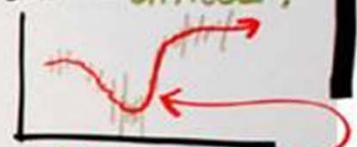
PCP-PEER WEBS



CARE COORDINATION

PCPs MUST QUALIFY TO BECOME A DESIGNATED MEDICAL HOME
TIME-LIMITED DESIGNATION
3 LEVELS OF MEDICAL HOME

THE TRANSITION IS DIFFICULT!



CHAOS PRECEDES IMPROVEMENT!

EVIDENCE-BASED TECHNOLOGY
NEW PAYMENT SYSTEM FOR PRIMARY CARE



HOW MEDICAL HOME MODELS COORDINATE CARE

Defining Coordination of Care and Transitions in Care

- Care coordination is defined as functions that help “ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.” (National Quality Forum, 2006)
- Focus is specifically on transitions between locations of care – an important aspect of care coordination – including institution-to-institution and information transfers between physicians, for example primary care practices and specialty practices, primary care practices and hospitals, and hospitals and long-term care facilities.

Stepping Up to the Plate (SUTTP) Alliance

Background and Purpose

- The failure to coordinate care between providers and organizations has been well documented and adversely affects both quality and efficiency of care.
- While a great deal of work has focused on improving care within organizations, a paucity of work has focused on improving coordination of care across providers and organizations including transitions between locations of care.
- To truly improve care, the implementation of systems to fill in gaps – the “white space” – between locations of care is an imperative.

Care Transition Intervention Activities

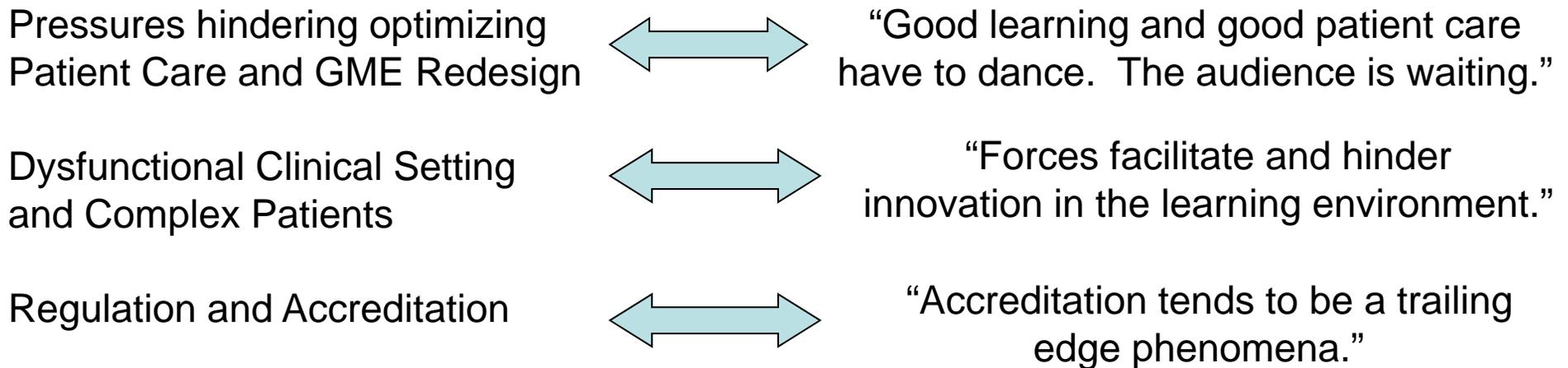
		Four Pillars		
Stage of Intervention	Medication Self Management	Patient-Centered Record	Follow-up	Red Flags
Goal	Patient is knowledgeable about medications	Patient understand Personal Health Record (PHR)	Patient schedules and completes F/U	Patient knowledgeable about indications
Hospital visit	Medication adherence	Explain PHR	Recommend PCP F/U visit	Discuss symptoms and drug reaction
Home visit	Identify and reconcile pre- and post-hosp meds	Review and update PHR and Discharge Summary	Emphasize importance of F/U visit	Assess condition
Follow-up telephone calls	Answer remaining medication questions	Remind patient to share PHR with PCP	Provide advocacy	Reinforce need for F/U with PCP

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Integrating the Patient-Centered and Coordinated Care Processes with GME?

Improving Health Care Value for Patients and Redesigning GME: Can it be done?



Philibert I, Leach DC, Batalden PB. Redesign of The Learning Environment. ACGME Bulletin, April, 2007.

Porter ME, Olmsted Teisberg MS. How Physicians Can Change the Future of Health Care. JAMA. 2007;297:1103-1111.

Ludmerer KM Johns MME. Reforming Graduate Medical Education. JAMA. 2005;294:1083-1087.

Integrating GME into the Patient-centered and Coordinated Care Models

- “There is now room for outcome measures, for attention to safe systems, and for more accurate assessments of progress.”
- “Once it is clear that improving patient care and resident education are the things that matter, smart people are free to be smart again.”

Then, innovating . . .

- “Programs participating in the EIP will be in a national experimental group with a smaller number and less restrictive accreditation standards.”
- “In return, participating programs will partner with the RRC-IM to design and test innovations in competency-based education and evaluation, in settings of outstanding patient care.”

Redesign of Graduate Training in IM

Table 2. Redesign of Graduate Training in Internal Medicine

Goals for Training Redesign	Current Concerns about Graduate Training in Internal Medicine
Retain 3 y of internal medicine residency training with a core component common to all internal medicine residents and customized training directed toward the trainee's specific career goals.	The traditional 3-y residency training model does not typically address specific needs related to the trainee's ultimate career plans.
Design residency experiences based on the educational needs and well-being of the trainee, ideally integrated with the service needs of the institution.	Factors other than the quality of resident education, particularly the service needs of the training institution, are driving the design of current training .
Develop better models of ambulatory training that improve the quality of ambulatory education, avoid conflicts with inpatient responsibilities, and convey the joys and satisfactions of the longitudinal care of adult patients .	Ambulatory experiences are typically a lower priority than inpatient experiences and are often neither well-designed nor appealing.
Use team-based approaches to optimize patient care and the design of training programs.	Particularly in the ambulatory setting, residents are often not incorporated into health care teams, which would improve the quality of patient care and allow greater flexibility in resident scheduling.
Allow faculty time for teaching and adopt substantive faculty recognition for teaching, complemented by faculty development focusing on a defined knowledge and skill set in teaching and evaluation.	Faculty involvement in the education and career development of residents has been compromised by conflicting productivity expectations, an inadequate reward system, and lack of training in educational methods.
Place the highest value during residency training on professionalism and on a culture that sets the expectation for a lifelong commitment to learning, self-reflection, and quality improvement.	The highly publicized failure of physicians to deliver recommended, evidence-based care could be considered at least in part the result of current training models.

Maintenance of Certification (MOC)

The Comprehensive Care Internist:

- should be held by those who indeed focus their practice on providing longitudinal, coordinated care for a panel of patients across the continuum of illness and sites of care.
- Focused Practice in Comprehensive Care should be distinct from the Internal Medicine certificate, as this strategy offers the best hope for allowing new knowledge, expectations and assessment tools to emerge with the goal of better serving patients.

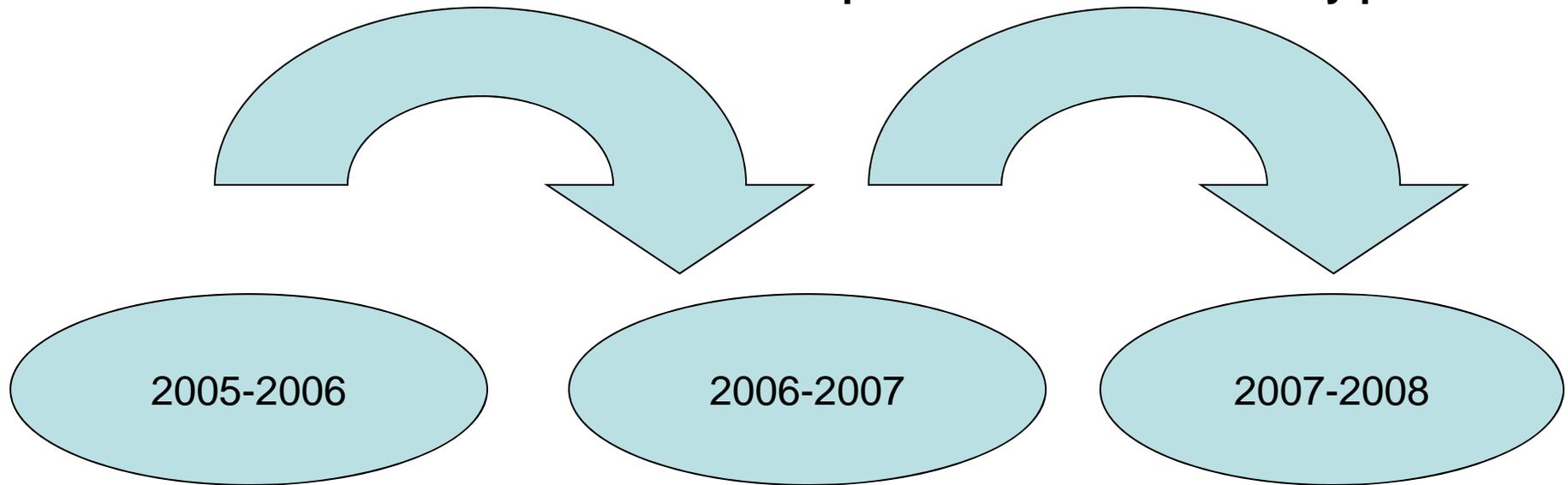
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UC EIP GME Redesign Model: Costs

Modification to Clinical Service Requirements:

- 1 new hospitalist FTE at the VAMC
- 3 additional hospitalist FTEs at UH (for a total of 7.5 FTEs)
- Decrease UH junior/senior team leaders from 2 to 1
- Eliminated the daytime admitting officer (AOD)
- Addition of 2 nurse practitioner to hospitalist services
- Addition of 1 new nurse practitioner to ambulatory practice



EIP Implementation



UC EIP GME Redesign Model: Costs

	Pre-EIP		Implementation		Post-EIP	
	FTE	Dollars	FTE	Dollars	FTE	Dollars
Personnel:						
Department						
Totals		118,701		167,574		172,602
Hospital						
		703,000		1,623,149		1,875,020
Sub-total		821,701		1,790,723		2,047,622
Hosp. Systems:						
Sub-total		40,000		40,000		790,000
Totals		861,701		1,830,723		2,837,622



UC EIP GME Redesign Model: Costs

Program Size:	PGY-1s:	Total Residents:	Proportional 2006-2007 EIP cost per:
Categorical	22	66	
Med Peds	7	28	
Preliminary	17	17	
Clinical Scientist	1	3	
Totals	47	108	108/\$1,830,723=\$16,944
Inpatient beds:			
University Hosp:	155	(24 ICU, 12 CCU)	
VAMC:	60	(12 MICU/CCU)	
Totals	215		215/\$1,830,723=\$8,513
Full-time Faculty:	185		185/\$1,830,723=\$9,894

Tension between Needing to Improve GME and Knowing How and When to Do It

- We cannot wait
- Any effort to improve is better than the current state
- Emulate successful organizations
- Effectiveness of some educational improvement methods are obvious
- Unproven strategies can catalyze innovation
- Framework of EBM does not always apply to educational improvement

Teaching Quality Improvement (QI): Curriculum studies (N=39)

- Most reviews of QI intervention describe attempts to improve knowledge of or adherence to guidelines instead of providing skills to implement system change

<i>Date of Pub</i>	<i>No. (%)</i>
Before 2000	2 (5)
2000	1 (3)
2001	2 (5)
2002	3 (8)
2003	3 (8)
2004	11 (28)
2005	9 (23)
2006	5 (33)
2007	3 (8)

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Current State of Health Care Spending

- Physician services currently constitute approximately 25% of all national spending for personal health services; approximately a quarter to a third constitutes payment for primary care services
- Thus, only 6–8% of total spending for personal health services currently represents payments to primary care physicians
- Current estimates of wasteful spending are as high as 30% of total expenditures
- 30% of Medicare beneficiaries who have 4 or more chronic conditions and account for almost 80% of annual program spending

The Reimbursement Model

- A new payment model for primary care that realigns incentives and makes possible the establishment and operation of accountable, modern primary care practices capable of providing the personalized, coordinated, comprehensive care essential to a well-functioning health care system



United Health Care's Premium Designation Program

Quality is only measured at a national level

- Metrics from established national guidelines and standards published and readily available and/or developed by expert consensus (chosen to be able to be measured in claims data)

Efficiency of Care is only measured at a specialty specific, local market level

- Evaluation is done by specialty comparing individual physicians to other like specialists in their own market
- Data is case-mix and severity adjusted to reflect the individual physicians practice

Focus

- Patient safety (duplication, interaction, monitoring)
- Compliance with guidelines (peer reviewed scientific evidence)
- Sequencing of care (diagnostic, treatments, and monitoring)

Then...

- A new model of care that includes a component of pay-for-performance is required
- Such a model should:
 - Reward quality, not volume
 - Support innovation in practice
 - Include differential reimbursement for practices that undertake significant efforts to address quality issues
 - Include expectations for reporting data for quality improvement efforts
 - Attract students and residents to primary care