



PRIMER

Emerging Primary Care Trends and Implications for Practice Support Programs

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Crossing The Chasm

Primary care clinicians in the United States stand at a crossroads. Their working relationships, interactions with other health care providers, and business structures must change if they are to navigate the road ahead successfully. With health care reform in the United States, smaller primary care practices are moving into consolidated models that include hospitals, health systems, and increased legal compliance issues, and they are experiencing unprecedented complexity in how they are expected to organize and deliver care.

There is growing evidence that external practice support is critical to providing the assistance and support practices need as they move through this period of significant change.¹ Identifying strategies to sustain these programs, whether bought or built, will be critical to ensuring that practices can make the necessary operational and clinical process changes needed to respond to the changing reimbursement environment.

Over the past four years, the authors have worked closely with nine alliances from the Robert Wood Johnson Foundation's (RWJF) *Aligning Forces for Quality* (AF4Q) initiative that are developing sustainable primary care practice support programs representing rural and urban communities across the United States.² In this paper, we outline our summary of seven trends relevant to providing sustainable primary care practices support. We also provide an overview of the evidence regarding the effectiveness of external practice support in improving process and health outcomes in primary care. We feature three case studies of prominent practice support programs, with a focus on how these programs have sustained funding and infrastructure in a changing environment. Finally, we outline recommendations to practice support program leaders for maintaining financially and strategically viable programs as the U.S. health care system, and specifically primary care practices, move through a time of significant change.

About *Aligning Forces for Quality*

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's at www.rwjf.org.

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Imminent Changes In Primary Care: Complex, Cross-Setting, and Patient-Centered Care

Trend #1: Increase in Complexity of Patient Care

The growing burden of chronic disease in the population, continued development of new treatments, an expanding evidence base about treatment effectiveness, as well as the growing capacity to measure performance and quality, push medical care providers to change their approach to caring for patients. This increasing burden of chronic illness in the United States is related to an aging population and a rise in risk factors such as obesity, sedentary lifestyle, and socioeconomic inequalities.³ Health economists project substantial increased burden of chronic illness in the U.S. population over the next 20 years that will further stress an ambulatory system ill-equipped for such patient complexity.⁴

Primary care physicians identify approximately 25 percent of their patients as complex, taking into account medical, social, and behavioral factors. As Grant and co-authors found in 2011, complicated care arises with mental health and substance abuse issues, increasing patient age, diabetes, and inadequate insurance coverage.⁵ Managing each of these aspects of care requires more attention than a single physician can provide during an average office visit. Some estimates suggest that a primary care physician with a panel of 2,000 patients would spend 17.4 hours per day providing recommended care.⁶

The chronic care model emerged as a framework to align several system characteristics to assist in managing complex patients with multiple comorbidities.⁷ Almost 20 years after the initial description of the chronic care model, we have seen numerous clinical trials documenting the effectiveness of its elements, including the prominence of team-based care and population management strategies. The routine integration of functional multidisciplinary teams in clinical practice has been difficult, as this is a departure from how most physicians were trained; many physicians provide all of the clinical care themselves. The patient-centered medical home model (PCMH), when it includes payment reform, begins to offer a context for clinical practices to implement the chronic care model in a functional and beneficial manner.⁸ It is evident that implementing the PCMH is time consuming, costly, and requires significant operational changes to transition to team-based population management.⁹ External practice support programs have demonstrated their effectiveness in accelerating the enhanced operational changes needed to improve care for patients with chronic illnesses in primary care practices.¹⁰

Trend #2: Coordination of Care Across Settings and Providers

Over the past 20 years, a broad range of care has transitioned from inpatient to outpatient settings. New network structures of loosely configured physician practices that lack coordination and integration have proliferated.¹¹ In the changing health care landscape, there is a need for a substantial improvement in cross-provider interface with patients in order to manage “episodes of care,” a concept that focuses on a health condition from its inception through evaluation and treatment as a means of measuring both the quality of care received and the efficiency of the care provided.¹² Some have argued that improvements in quality and productivity will be bolstered by strong incentives for efficient and coordinated care in this new system.¹³

Trends Shaping the Future of Primary Care

1. Increase in complexity of patient care
2. Coordination of care across providers and settings
3. Acquisition of primary care practices by hospital and health systems
4. Adoption of Electronic Health Record (EHR) systems
5. Changes in workforce in primary care settings
6. Reform in payment structures and reimbursement incentives
7. Transition to patient-centered care, “patient empowerment”

“The primary care chasm—between what we have and what we need—is too wide for small steps. Primary care needs a leap, not a step.” (Margolius, D., and T. Bodenheimer. 2010. “Transforming Primary Care: From Past Practice to the Practice of the Future.” *Health Affairs* 29 (5): 779-784.)

To move toward the “...high-value health care delivery system, which is interdependent and mutually reinforcing, primary care practices will need to overhaul their existing operational and clinical systems.” (Porter, M., and T. Lee. 2013. “The Strategy that Will Fix Health Care.” *Harvard Business Review* 91 (10) 50-70.)

Information system and infrastructure redesigns are needed in this effort to manage patients with chronic conditions effectively and efficiently; changes in payment structures are also necessary to support the increased focus on medical neighborhoods, a concept defined by the American College of Physicians as the interface between the patient-centered medical home and specialty/subspecialty practices.¹⁴ Both hospitals and physicians must shift their thinking to reflect the changing approach to providing care. Accountable care organizations (ACOs) will require collaboration of all kinds—clinical, administrative, and fiscal.¹⁵ Provider-led ACOs are founded upon the idea that the organization is responsible for ensuring positive patient and financial outcomes—quality and cost—for their defined population.¹⁶

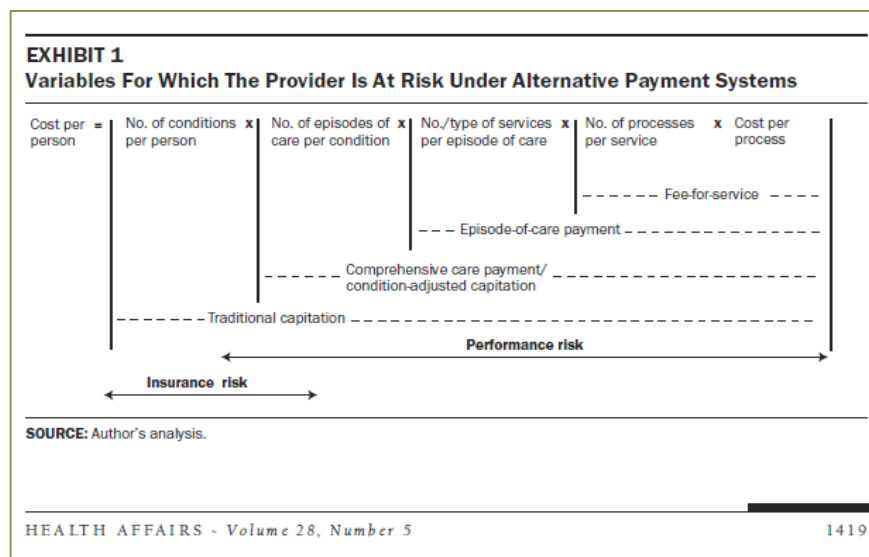
The focus on decreasing the fragmentation of care and improving information transfers will be a considerable undertaking for many practices as they begin collaborating and aligning across providers. Expanding practice support services to include specialty clinics is an important opportunity to facilitate coordinated care between specialists and primary care providers. Interactions between primary care providers and hospitals also must improve in the shift toward comprehensive care management, especially around care transitions. A global payment system in which hospitals are linked to physicians through reimbursement provides an incentive structure for this collaboration.¹⁷

Collaboration, both internal and external to the practice, must increase. The traditional physician-patient relationship can be supported by other members of the care team. The shift to more pro-active, population-based care will require these other players—medical assistants, registered nurses, nurse practitioners, physician assistants, front-desk staff, behavioral therapists, clinic managers, social workers, pharmacists, and nutritionists—to be involved in the redesign of primary care.¹⁸ External practice support programs can play a unique role in helping physicians and other staff in developing the competencies and team-based approach, using quality improvement (QI) methods to accelerate cultural and structural changes to redefine roles, and providing training and support to leaders as they implement these changes.

Trend #3: Acquisition of Primary Care Practices by Hospitals and Health Systems

Primary care physicians who once thrived on the entrepreneurial aspects of owning a practice are finding it more difficult to sustain themselves financially while maintaining some level of work and life balance.¹⁹ Increasing numbers of them are either aligning with larger organizations or having their practices acquired.

A 2009 study by Harold Miller describes the impact of alternative payment structures on primary care in the future that are driving this trend. Payment will be based on five variables for which a provider is at risk.²⁰



As the move toward increased accountability and measurement are built into reimbursement and incentive payments, practice infrastructures will be overburdened, forming a compelling reason for joining a provider network, health system, or accountable care organization (ACO).

Systems across the country have been acquiring primary care physician groups to expand their referral networks and prepare for a future in which they will have to manage the health of their patient populations while being held accountable for meeting cost and clinical outcome goals. Stronger physician alignment

will better position these systems to meet the demands of payers, particularly as more health plans move to narrow networks. The Patient Protection and Affordable Care Act (ACA) presents opportunities for health systems with integrated physicians to participate in potentially lucrative alternatives to fee-for-service payment, such as accountable care and bundled/shared reimbursement programs. Having a strong physician network may promote the success of

these alternative payment and delivery models.²¹ Ambulatory care is an increasingly important contributor to the bottom line and will continue to be central under future payment models.

There are a growing number of external practice support programs and consultants who provide technical assistance to health systems, independent practice associations (IPAs), and ACOs to support ambulatory transformation, with many organizations looking externally for a “turnkey” program that can provide direct practice support, data reporting, and peer-to-peer learning opportunities. Others have developed an internal infrastructure to provide this support.

Trend #4: Adoption of Electronic Health Record (EHR) Systems

The Health Information Technology for Economic and Clinical Health (HITECH) provisions of the 2009 American Recovery and Reinvestment Act allocated nearly \$30 billion to offer providers incentives to become “meaningful users” of electronic health records, or EHRs. Meaningful use refers to the federal Department of Health and Human Services requirement that electronic systems meet “certain measurement thresholds that range from recording patient information as structured data to exchanging summary care records.” The hope is that widespread uptake of EHRs will drive improvement in both efficiency and quality of care.²²

The Agency for Healthcare Research and Quality’s (AHRQ) Health Information Technology Ambulatory Safety and Quality Summary outlines 10 aspects of ambulatory care in which health information technology (health IT) can be used to improve safety and quality: 1) developing and testing quality measures, 2) capturing and integrating data to support quality improvement, 3) providing clinicians with patient-specific information, 4) offering clinical knowledge and decision support, 5) providing clinicians and patients access to medical information, 6) improving shared decision making and patient-clinician communication, 7) managing medications, 8) supporting patient self-management, 9) integrating patient information across transitions in care, and 10) coordinating care and improving outcomes for vulnerable populations.²³

Many challenges arise for primary care practices as they approach the task of purchasing and implementing an EHR system, including cost, selecting a vendor, lack of important functionality such as patient registries, integrating the EHR into existing administrative and operational systems, insufficient training, and the challenge of modifying clinic workflow around the EHR. One research study found that the presence of highly skilled, clinical staff was associated with substantially greater odds of a practice being a high performer on quality and efficiency among physicians with an EHR.²⁴ A recent study of external practice support for using health IT in primary care supports found that a practice support program can play a key role in supporting EHR implementation.²⁵ Use of the EHR to support patient care and performance improvement will continue to be a trend over the next several years, and practice support programs should consider how to develop core health IT competencies to support the pressing needs of primary care practices. In their study of external practice support for meaningful use of health IT, Fernald and colleagues suggested that the following areas of support are important to practices:²⁶

- Technical experts for health IT selection, training, education, and hands-on troubleshooting related to EHR implementation, upgrades, enhancements, data requirements, and data elements
- Forums and support for community collaborations
- Translation of new regulations and rules
- External accountability

Two case studies outlined in this paper include a strong emphasis on supporting technological capability for primary care practices across a region.

Trend #5: Changes in Workforce in Primary Care Settings

One of the most challenging trends primary care practices face is the need to retool their workforce.²⁷ The 2014 PCMH standards emphasize requirements for new roles and responsibilities for every team member within the medical home.²⁸ Primary care practices and clinics struggle to link the anticipated needs of patient populations to existing and expanded roles of clinical and support staff within their practices, often exposing deficiencies in skills, training, and human capital.^{29, 30} External stakeholders require more of primary care, independent of PCMH requirements, to manage more complex patients proactively, coordinate care across the medical neighborhood, and play a more proactive role in care transitions.

As a result, the roles, responsibilities, tasks, and workflow of the primary care team are in constant flux. Medical assistants are becoming panel or registry managers and health coaches. Nurses are moving from primarily triage to care management and coordination. Clinicians are shifting tasks and delegating routine care responsibilities to others on their staff.³¹ Some primary care settings are incorporating new team members such as pharmacists, mental health workers, social workers, and community health workers.³² This is challenging because these new team members must be integrated in a way that improves overall team function and efficiency. Lastly, practices often do not designate non-clinical staff (such as practice administrators) to quality improvement and project management, as these roles are already overburdened with responsibilities.

The Robert Wood Johnson-funded project *Primary Care Teams: Learning from Effective Ambulatory Practices* identified 30 exemplar primary care practices that are innovating around the use of their workforce to deliver team-based care. Innovations, case studies, tools, and resources are available at www.improvingprimarycare.org.

Practice support programs have an opportunity to assist care teams in testing and implementing new work flow, work with practices to develop and revise job descriptions and competency checklists, and work with leaders to incorporate the new competencies into staff evaluations. Some practice support programs work with local educational institutions to develop revised curriculum and staff competency training based on new requirements. Others provide practice management training and support to improve practices' capacity to change their culture using adaptive and other evidence-based frameworks. Sustainable practice support programs should consider practices' current state and needs and help them adjust workforce expectations accordingly.

Trend #6: Reform in Payment Structures and Reimbursement Incentives

Fee-for-service and capitation payment models currently dominate reimbursement. The former does not financially reward contributions of non-physician staff and reimburses only services performed in the office with the patient present. Capitation models also lack adequate incentives for improvement by encouraging only a minimum baseline of care. Although there is movement toward combining fee-for-service and performance-based payment models, successful implementation of a blended payment model will be challenging for many primary care practices. Incorporating incentives for providers based on quality measures, shared savings, and patient experience is an important step toward payment reform, but incentives based upon these components are not widely understood by providers and thus may not be successful at bringing about the desired outcomes.³³

The original principles underlying the PCMH model include the need to address primary care payment structures at the practice level. However, PCMH adoption must be measured in order to link payment to practice achievements.³⁴ Such measurement remains complex, despite the existence of multiple recognition standards such as the National Committee for Quality Assurance's (NCQA) *The Physician Practice Connections-Patient-Centered Medical Home Tool*.³⁵

ACOs also focus on meaningful payment reform, as providers within the organization are accountable for the quality and cost of their patients' care. It is possible that a combination of risk-adjusted monthly payments for each patient with additional performance-based revenue might successfully reward providers for providing care in a more holistic way.

Meaningful payment reform must occur alongside practice improvement in order to reward providers for better outcomes. Substantial work remains to align the payer and provider communities in this transition.³⁶ Practice support programs are uniquely positioned to facilitate PCMH adoption and ACO development and have many tools at their disposal to assist practices in navigating the challenges required to make such fundamental changes.

Trend #7: Transition to Patient-Centered Care, "Patient Empowerment"

The Institute of Medicine (IOM) defined six critical dimensions of quality, and it named patient-centered care one of these dimensions. Patient-centered care is defined as: "Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."³⁷ Patient-centered care has received substantial policy interest because traditionally, the health care system has not fully engaged patients in decision-making. Dramatic variation in care across the country usually reflects clinical practice

more than patient preference.³⁸ This trend also reflects health care providers' more traditional focus on intermediate health outcomes (e.g., A1C levels in patients with diabetes) instead of outcomes that patients care about, such as medication side effects and cost. The patient-centered approach seeks to balance patient values with intermediate health outcomes that patients may or may not find important. Moreover, evidence is emerging that such a patient-centered approach improves health outcomes and reduces costs.³⁹

As health care has attempted a transition from an acute-care model to a chronic-care model, the most effective strategies tend to engage patients more fully in their care and recognize that the ultimate decision on how to proceed rests with the patient. A patient-centered approach establishes a dialogue between patient and clinician as they decide together on the approach that is most consistent with the patient's values and preferences. As treatment options for chronic diseases have expanded, integrating the patient into decision-making has become paramount but also more complex. The clinician's job is often to help the patient evaluate complicated evidence about effectiveness while keeping in mind the patient's values and preferences.

Most clinicians want to take a patient-centered approach and believe they provide patient-centered care. Although they do this some of the time, the current payment structure of medical care limits patient-centeredness in the following ways: 1) visit-based payment encourages volume over relationship; 2) practice design and management has allowed limited patient input; and 3) outcome measure design has allowed limited patient input as well and often does not measure outcomes that patients care about. Better systems will place the patient, rather than the doctor, at the center of care and include the patient in the redesign.

Evidence-based programs designed to support patient empowerment have proliferated in regional practice support programs, with a focus on supporting practices as they embed these approaches into daily practice. Practice support programs also have been instrumental in selecting and supporting patients who work on primary care redesign and QI teams, coaching practices and patients on how to involve the patient effectively in these efforts.

Effectiveness of Practice Facilitation in Accelerating Practice Change

Practice facilitation is one of four broad categories of external supports that can be effective in assisting practices in their QI work and helping them develop robust QI capacity. The others are data feedback and benchmarking, expert consultation to implement evidence into practice, and peer-to-peer learning networks.⁴⁰ One of the common elements across many practice support programs is the use of a practice facilitator to work individually with practices. In this section, we focus on the evidence and lessons learned from three programs that employ practice facilitation as a major support mechanism.

Growing evidence indicates that local change agents can successfully facilitate quality improvement in primary care practices.^{41, 42, 43, 44} Evidence comes from published studies, a recent systematic review, and the experience of several state-wide initiatives to build a practice support infrastructure. These demonstration programs also provide unique insights into practice support activities.

Over the past 15 years, researchers have used a practice support infrastructure that includes facilitators to help practices improve preventive services delivery, manage patients with chronic disease, and use health information technologies.⁴⁵ Researchers also have studied the impact of practice facilitation on efforts to meet PCMH criteria. The National Demonstration Project (NDP) study compared two implementation approaches, facilitated and self-directed, across 36 primary care practices. The research team found that facilitation increased the practices' capability to make and sustain change and increased their organizational capacity to engage in ongoing QI.⁴⁶

Baskerville, Liddy, and Hogg (2012) conducted a systematic review and meta-analysis of 23 separate studies of practice facilitation use. They concluded that: "Practice facilitation has a moderately robust effect on evidence-based guideline adoption within primary care."⁴⁷ In many, if not most, of the studies included, practice support included shared learning experiences, such as peer-to-peer learning networks, in addition to individualized support from a practice facilitator.

Others have examined the cost savings associated with practice facilitation. One study found that practice facilitation reduced inappropriate and increased appropriate screening tests in 22 primary care practices serving approximately 100,000 patients in Canada.⁴⁸ The intervention resulted in an annual savings per physician of \$3,687 and per facilitator of \$63,911 (Canadian dollars). The estimated return on intervention investment was 40 percent.⁴⁹

AHRQ awarded four cooperative demonstration grants to create an Infrastructure for Maintaining Primary Care Transformation (IMPACT)—Support for Models of Multi-Sector, State-Level Excellence. These grants supported model state-level initiatives using primary care extension agents in small and mid-sized independent primary care practices to assist with primary care redesign and transformation. The following are key insights from this experience:⁵⁰

- Basic competencies for practice change include project management and organizational development work.
- Redesigning effective practice work processes is more complicated than anticipated.
- The community (integrated networks or the medical neighborhood) is important as the point of intervention.
- Building change capacity into a local partner rather than working directly with practices is important.
- In some states, the issue is not a lack of QI support but rather too many different organizations involved in QI support activities.

Table 1: Emerging Trends and Implications for Practice Support Programs

Emerging Trends	Practice Competencies/Skills Acquired Through External Practice Support
Increase in Complexity of Patient Care	Population registries, risk stratification models, chronic condition-specific standing orders, decision support aids, self-management programs, group visits
Coordination of Care Across Providers and Settings	Information transfer between specialty and primary care, health care teams, self-management programs, care transitions programs, medication reconciliation, care compacts, identifying “hot spotters”
Acquisition of Primary Care Practices by Hospitals and Health Systems	QI infrastructure support for health systems specific to primary and specialty clinics, practice workflow analysis redesign, both operational and clinical systems
Adoption of Electronic Health Record Systems	Selection, customization, and adoption from paper to EHR, systematic data reporting to manage populations, systematic flags and orders to incorporate population health principles, train panel managers
Changes in Workforce in Primary Care Settings	Job reclassifications, staff training, adaptive behaviors to move from the traditional to new model of care, new work flow, and redesign with new care team members
Reform in Payment Structures and Reimbursement Incentives	Value proposition for QI/redesign, optimizing payment and incentives, adoption of EHR meaningful use, adoption of PCMH standards, MOC- IV certification
Transition to Patient-Centered Care, “Patient Empowerment”	Decision support aids, self-management support, health coaches, motivational interviewing, incorporating patients into QI efforts, using patient experience data to drive improvement

In addition to AHRQ’s four grants, since 2008, Vermont Blueprint’s Expansion and Quality Improvement Program (EQuIP) has provided facilitation or coaching to primary care practices throughout the state as one component of the Vermont Blueprint for Health, the state’s broader health reform initiative. EQuIP’s facilitators assist practices in becoming patient-centered medical homes and implementing and using health information technology supports, among other activities. Unpublished findings from the Vermont Blueprint program suggest significant cost savings and improved overall quality of and access to health care.⁵¹ Important lessons learned by the EQuIP program to date include:

- There is no ready workforce for practice support facilitation. In most cases, programs need to build their own.
- Directly hiring and managing facilitators makes it easier to stay true to the intervention model.

- Including electronic health record (EHR) consultants on facilitation teams intensifies the effectiveness of both the facilitator and the consultant and helps both work together to support PCMH transformation at the practices.
- Practices that are late adopters need a different facilitation approach than early adopters.
- Facilitators are most useful when the focus is long-term commitment to improving care rather than an intermittent goal by the practice on the NCQA recognition.

In summary, a growing body of evidence supports the need for sustained practice support programs that can provide ongoing development, training, and resources for primary care practices to realize their potential, especially as these trends emerge. The ability to work directly with a practice facilitator in addition to the other important support mechanisms helps practices increase their ability to make needed changes to operational and clinical processes.

Characteristics of Three Successful Practice Support Programs

We interviewed three organizations with different infrastructures, programmatic areas of focus, and funding streams to provide examples of how practice support programs have been developed and sustained. One organization is an AF4Q Alliance; the directors from the other organizations featured in this section have been subject matter experts for the AF4Q Practice Facilitation Support Program Affinity Group, providing consultation to the nine AF4Q communities that run practice facilitation programs.

The purpose of these case studies is to understand better how these organizations positioned their programs over time as their markets shifted and share what business approaches these program administrators used. We also identified key lessons and insights that could inform regional health care improvement collaboratives and others wanting to sustain practice support programs as funding opportunities end and new opportunities unfold.

Cleveland, Ohio: Using Data to Improve Care and Outcomes Through Effective Collaboration, Education, and Consultation With Stakeholder Groups⁵²

Better Health *Greater Cleveland (Better Health)* is a regional health improvement alliance of providers, patients, purchasers, community organizations, and health plans. Established in 2007, this nonprofit collaborative's vision is to help make Northeast Ohio a healthier place to live and a better place to do business. Serving as a trusted, neutral convener of these regional stakeholder groups, *Better Health* brings together transformational leadership to collaborate on best practices to improve health care delivery and payment systems. Through a growing number of clinical partners, *Better Health's* work improves the health of more than 70 percent of the chronically ill population residing in Cuyahoga County and helps these individuals experience better control of their chronic conditions. Coaches facilitated care teams at local community health center Neighborhood Family Practice to implement huddles, improve teamwork, and create new workflow processes to ensure more patients received the care they needed. Improvements helped the health center boost the percentage of its patients whose high blood pressure is well controlled and continues to increase achievement on evidence-based diabetes standards, even as its patient volumes grew.

Better Health is one of the 16 communities involved in the Robert Wood Johnson Foundation's AF4Q initiative. As such, it has received programmatic and infrastructure funding over the past seven years and has used a portion of grant funds to develop and provide practice facilitation, consulting, and education services to its membership. Quality improvement is a vital component of its work, leveraging data from provider electronic health record systems to identify opportunities and best practices in improving care and outcomes using nationally endorsed and locally vetted standards. The fee-based membership model includes providers and hospitals from several of the major health systems; independent primary care practitioners; extended, post-acute care providers; hospice; community organizations; large, self-insured employers; and local and nationally based health insurers. Along with the two all-day learning summits offered each year, membership includes individualized local-level coaching support, using data and information to improve quality of care delivery, reducing avoidable hospital utilization, and improving health outcomes for people with chronic conditions such as hypertension, heart failure, depression, and diabetes.

Better Health's reputation as a neutral convener with expertise in data reporting, practice facilitating, and QI initiatives has put it in an excellent position to be the "go-to" organization for wrap-around services in ambulatory care, including PCMH transformation and care coordination. The growing technical expertise *Better Health* has established over the

past few years includes managing care for populations most likely to be frequent users of medical services and assisting more than 50 primary care practices in achieving NCQA PCMH recognition.

With growing statewide interest in health care delivery and payment transformation, *Better Health* is uniquely qualified to provide a bundled set of services of practice support, peer-to-peer learning networks, and data and benchmarking services to support the Ohio Governor's Office of Health Transformation agenda for change. It is currently assisting the state as a core team member, designing the roadmap for statewide expansion of PCMH and the rollout of bundled payments for five medical situations that require coordinated care: acute asthma, perinatal care, chronic obstructive coronary disease, percutaneous coronary intervention, and joint replacement. *Better Health* also serves as an anchor organization for the Health Improvement Program for Cuyahoga County, a consortium of more than 50 community organizations focused on improving management of chronic disease and patients' quality of life with an emphasis on health equity. Participation in this program has brought new visibility and awareness to the data-driven coaching, consulting, and education services *Better Health* provides. That attention has resulted in engagement of several new members and community organizational partners who will be instrumental in helping to accomplish *Better Health's* vision and mission.

Given these emerging opportunities to accelerate its work, *Better Health's* leadership is focused on building its internal capacity for data center and coaching, consulting, and educational support services. The organization has initiated a rigorous strategic and business planning process with its Board of Directors to position *Better Health* optimally for the future. Executing this plan includes implementing the necessary infrastructure and standards—"schools, tools, and rules"—for operating at scale efficiently and effectively. With the assistance of the Improving Performance in Practice (IPIP) Technical Assistance Team (funded through the RWJF initiative), the staff of *Better Health* has developed a product prioritization matrix, a prospective client pipeline, and resource planning tools, all of which it uses in conjunction with its financial income/expense forecasting reports.

Los Angeles, CA: Enhancing Adoption of Best Evidence in Safety-Net Practices Using Practice Facilitation⁵³

LA Net is a community- and practice-based research and resource network (PBR²N) focused on reducing health disparities in Southern California. The organization is set up as a free-standing 501c3. LA Net provides training, technical assistance, and staff support to safety net practices in Los Angeles to conduct practice-based and -led research. In the past four years, LA Net has expanded its services to provide support to these practices to implement elements of the PCMH and to speed adoption of results of patient-centered outcomes research (PCOR). LA Net supports the latter through the use of primary care practice facilitation teams (PF). LA Net is viewed as a national leader in its support of safety net practices, including Federally Qualified Health Centers (FQHCs), community health centers, and private practices using practice facilitators.

LA Net places practice facilitators into practices for a half-day each week. Facilitators are trained in quality improvement methods, health IT optimization, transforming to patient-centered medical homes, and processes for engaging patients as partners in both care and practice transformation. Because of the broad range of skills needed to support practices in this work, LA Net prefers to use facilitation teams when possible. Each PF team is led by an expert in quality improvement and includes an expert in acquisition of data for performance reporting and an expert in health IT optimization to support PCMH functions, including guideline implementation and population management.

LA Net is in a period of significant transition as it expands from its original mission of supporting practice-based research to one that also includes quality improvement and practice transformation. What will it take for LA Net to sustain its program through this expansion of its scope of work? Lyndee Knox, the executive director, defined a number of strategic priorities. The first is to make sure the services align with practice need by more fully engaging practice clinicians and administrators in designing facilitation services. The second is to continually develop their current workforce of improvement facilitators. These individuals need to be very well trained and able to respond to the needs of different practices, both those just beginning to work on practice improvement and those more experienced practices in need of facilitators with a more advanced set of improvement skills. Dr. Knox explains: "We are transitioning from a research organization into one that supports implementation of research findings in care and expansion of the internal capacity of practices to continually improve over time. This requires the addition of a new type of workforce to our PBRN staff. This also means having access to training and effective supervision for this staff, as well as models of

effective work in this area. ARHQ has produced a series of manuals and training curricula that we have used to help us to expand our organization to include this new type of service. The content of training and the types of support provided by our facilitators needs to be defined in partnership with our practices, otherwise we risk missing the mark.”

Dr. Knox is particularly interested in the idea of a national primary care extension program. “This is a powerful idea and one that is very much needed, especially by the smaller practices we work with,” she said. “They lack internal resources they need to support a program of continuous improvement and are not part of larger systems that could provide this for them. An infrastructure like the primary care extension program can connect them to the quality improvement and best-evidence grid, so to speak, and make it possible for even the smallest practice to keep pace with and provide the highest-quality care.” Stakeholders from the health care community, including practices, health plans, and even businesses, will need to make the case for this type of infrastructure in order for it to move forward.

As LA Net seeks funding from foundations, health plans, and other sources to support this expanded scope of work, Dr. Knox believes the field needs to continue to build the case for facilitation. While the evidence base exists to show that facilitation is effective in improving quality of care and use of treatment guidelines, this now needs to be connected to dollars. Funders will want to see how facilitation leads to reduced costs as well as improved quality. While some practices are willing to pay for these services, practices that are the most in need of this type of support are the ones that are the least able to marshal the resources to pay. Fee-for-service is not a viable model for this type of work. It will most likely require support from both public and private sources. Funding also needs to move beyond a focus on specific projects to long-term, operational funding models. Current funding for facilitation work is primarily organized on a project-by-project basis, which leads to short term, piecemeal work (e.g., a grant to support chronic kidney disease guideline implementation). Fragmented funding for improvement leads to fragmented improvement, which was useful in the early stages of trying to understand and develop the intervention and workforce. The field is ready for long-term operational funding now, rather than project-based funding. This means funding that extends five to 10 years and that supports improvement work determined by community or regional needs rather than around particular diseases or issues. LA Net has begun working to stimulate region-wide interest and investment.

North Carolina: Statewide Quality Improvement Via Health Education Centers⁵⁴

North Carolina’s Area Health Education Centers (NC AHEC) practice support program is one of several quality improvement offerings within NC AHEC. The parent organization is based in the University of North Carolina at Chapel Hill’s School of Medicine. NC AHEC’s facilitation program combines experienced immediate credibility and access to practices across the state with a 40-year relationship with North Carolina medical care providers. NC AHEC has a reputation for innovation, and its strong leaders have maintained an excellent reputation with state government and other partners statewide. Approximately 20 percent of the Practice Support Program budget is provided by funds that NC AHEC receives annually from the state legislature, a state-funded budgetary line item allocated to NC AHEC since 1974.

A statewide network of quality improvement consultants for primary care practices in each NC AHEC region provided the opportunity to become a federally funded Regional Extension Center (REC) in 2010, supporting more than 1,140 practices with approximately 50 practice consultants. Their consultants worked collaboratively to provide informed, technical knowledge with “seasoned practicality” to help practices select, implement, and meaningfully use EHRs. At the same time, NC AHEC kept the focus of the practices on improving patient care outcomes. NC AHEC’s practice support services include support in EHR vendor selection, strategies to meet meaningful use criteria when combined with practice transformation, patient-centered medical home recognition using quality improvement methods, and the capacity to gain monthly practice-level data reports for improvement and provide population-level data out of multiple EHR systems.

Practice consultants are hired locally, going through an initial training with continuous support to ensure they are working efficiently and effectively with their assigned practices. They work in consulting teams, where they are matched with consultants with different expertise so that as a team they can provide health IT and QI support. In general, each consultant team is assigned to a practice in one of nine regions. To determine staffing ratios, the program director considers the time differences in providing vendor and technical knowledge versus the more “adaptive” practice work required in PCMH transformation as well as geographical obstacles and the level of practice engagement.

As NC AHEC's federal grant funding comes to an end in February 2015, the program director already has set in play layers of additional funding to support this work further. Ann Lefebvre, associate director of statewide quality improvement and the director of the practice support program, said there will not be a significant change in the organization's strategic focus: "We are very deliberate about whether a potential funding stream aligns with the work we want to do, which is practice transformation with a focus on improved clinical health outcomes. We have a set of questions as we review funding opportunities: Does it align with our mission, and what we are good at? Is the 'squeeze worth the juice'?" Ms. Lefebvre described their program as an "aircraft carrier," with the mission to improve health outcomes across the state. "As incentives align with the trajectory of our aircraft carrier, we will take the work on; if incentives don't align, we may need to pass on some opportunities that have the potential for distraction," she said.

As a regional institution, the NC AHEC program office subcontracts with the nine regional offices for all of the practice-based work. This allows for a wonderful opportunity to engage every practice in the state fully; however, it also means that contracts or grants that are smaller in size and scope are very difficult to execute at the state level and may need more of a regional focus. These smaller contracts would be negotiated and delivered within a specified AHEC region. Although they will experience a significant decrease in budget with the end of the federal REC grants, the program already is moving forward with a plan to seek 50 percent of future funding through the Medicaid 90/10 share via the Division of Medical Assistance in the State HIT/Implementation Advanced Planning Document. With this funding, NC AHEC will help private practices in the state achieve the second stage of Medicare's Meaningful Use incentive program and optimize the use of the Health Information Exchange and patient portals.

NC AHEC's work achieves results throughout North Carolina. Ann Lefebvre said, "When we started in 2006, Warren Newton, MD (board member and now program director of the entire NC AHEC), predicted we would be in all 100 counties within a five-year period of time. At the time, I could not imagine how this would happen. My recommendation to practice support programs is to 'think big.' The opportunities are there—'build for what you think is impossible.'"

Table 2: Key Characteristics of Three Mature Practice Support Programs

	Budget/Staffing Model	Reach (# of Practices, Geographic)	Products/Services	Institutional Characteristics	Business Planning Approaches	Funding Streams for Practice Support Products/Services
Better Health Greater Cleveland Practice Facilitating/ Consultative Services	<p>\$200K for direct coaching, consulting, and educational services</p> <p>2.0 full-time equivalent consultants</p>	7 Counties, 10 hospitals, 9 major health systems, and other stakeholder groups	<ul style="list-style-type: none"> • PCMH transformation • Lean/Six Sigma training • Decision support including Choosing Wisely workshops and Chronic Disease Self Management Programs (CDSMP) • Workforce curriculum development/training in local community college (medical assistant training) • Meaningful Use/EHR • Workflow analysis/redesign • Implementing team-based care • Reducing disparities consultation • Peer-to-peer learning • Data systems for ongoing feedback on performance • MOC-IV certification 	Not for profit; Co-located with Metro Health, large public hospital, affiliated with Case Western University; strong reputation in QI and measurement; public reporting capacity	<ul style="list-style-type: none"> • Strategic planning and business plan development with staff, leadership, and Board of Directors • Established three strategic priorities aligned with strengths, organizational vision, and mission • Financial analysis and planning with formal “sustainability” committee • Business Tools: Product Prioritization Matrix, productivity tracking • New Client Prospect Pipeline/resource planning (link) 	<p>Current:</p> <p>Net income: break even 15% membership dues 51% earned revenue 34% grants</p> <p>Future:</p> <p>Net income: 10% or better 20% membership dues 50% earned revenue 30% grants</p>
LA Net	<p>\$700K-\$1M</p> <p>Current 3 full-time equivalent research assistants/practice facilitators</p>	LA and Orange County safety net providers: FQHCs, private practices, Veteran’s Administration	<ul style="list-style-type: none"> • Practice-based research • Workforce training (care coordinators, community health workers, medical assistants, nurses) • Evidence translation • QI coaching and interventions to improve care for underserved • Specialty care access • EHR support • Data systems for ongoing feedback on performance • Population management 	Not for profit; strong reputation of working with community health clinics	<ul style="list-style-type: none"> • Informal business plan using on-line template • Board input • Collaborative of late-career FQHC professionals interested in product and service development 	<p>Current:</p> <p>50% grants (PBRN/AHRQ) 50% contract</p> <p>Future:</p> <p>30% grants 60% contract 10% fee-for-service and venture philanthropy</p>
NC AHEC Quality Source Program	<p>\$3.9M</p> <p>Current 32 full-time equivalent practice consultants</p>	<p>Statewide—all 100 counties</p> <p>1,140 practices supported through the NC AHEC REC</p>	<ul style="list-style-type: none"> • PCMH Transformation • Clinical redesign/QI • Meaningful Use • EHR selection, optimization, and enhancement • Workforce training (medical assistant training program) • Medical Education Credits • Data systems for ongoing 	Division within NC AHEC, organization placed in UNC School of Medicine; immediate credibility and access to practices across the state	<ul style="list-style-type: none"> • Long history of broad collaboration with health entities across the state • Decision model to determine interest in prospect proposal staffing model to 	<p>Current:</p> <p>60% Federal/REC 20% Federal/CDC 15% AHEC (state appropriated) 4% private contracts 1% philanthropic</p> <p>Future:</p> <p>50% (Medicaid 90/10 share via Division</p>

			feedback on performance <ul style="list-style-type: none"> • Empanelment and Risk Stratification models • MOC- IV certification • Population management 		determine staff ratios	of Medicaid Assistance) 25% AHEC (state appropriated) 20%-25% private contracts (with health systems) 1% philanthropic
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Discussion

Practice support programs are at risk if they do not develop the capacity to address these emerging trends. Program administrators must take inventory to know they are planning well for the changing face of primary care outlined in this paper. They must develop an understanding of the regional market, how and when these health care trends will impact the market, and how this information will influence their portfolio of products and services. Building the business case (sometimes referred to as the value proposition) for these programs is a high priority for this field and must be shared across programs.

For practice support programs to bring greater value and focus, we recommend practice support program leaders consider the following:

1. *Work with your organization's board and other key stakeholders* to gain an understanding of your market and how these emerging trends will impact and change the market.
2. *Build new services that address emerging trends*, including workforce training, care across the continuum, patient-centered approaches, and population management strategies.
3. *Be at the table, and "think big."* Practice support program leaders need to position themselves as thought leaders where large regional, statewide, and ACO initiatives are being designed. They must be ready to develop or design new products and services upon better understanding the anticipated demand for these services.
4. *Bundle practice support services* to include QI reporting, practice support services, and peer-to-peer learning networks, as well as care coordination and health coaching programs.
5. *Use business approaches* to determine strengths, funding streams, and staffing

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