We Promise to provide

Personalized Care

by listening, treating you with respect and putting your needs and interests first.

Affinity's Medical Home Journey – Operational, Clinical and Financial Perspectives

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Affinity HEALTH SYSTEM

Affinity Health System

- **Top 100 Integrated Healthcare Networks in the Nation**
- **Three (3) Hospitals**
  - St. Elizabeth Hospital, Appleton
  - Mercy Medical Center, Oshkosh
  - Calumet Medical Center, Chilton
- **Network Health Plan**
  - 135,000 Members
- **Affinity Medical Group**
  - 264 provider multi-specialty group located in the Fox Valley area of Wisconsin
  - 878 non provider employees
  - 13 Level 3 NCQA Accredited sites, 9 submitted for Accreditation and 1 to submit prior to October 31
- **Sponsored by Ministry Health Care & Wheaton Franciscan Healthcare**

Agenda

- Establishment of Vision and Champion
- Hoshin process: Core/Coordination Team
- Team Roles
- Health plan partnership
- Physician Compensation Team

Establishment of Vision and Champion

The “Wonder” Years

- Vision: Medical Home is the way to improve quality and delivery of care in a PC shortage and for the future.
- Physician leader with the vision convinced senior leadership to be supportive of this vision.
- It was critical to have top Executive level support
- Pilot at two primary care departments: Kaukauna FM and Koeller IM.

The “Wonder” Years

- Network Health Plan partnered from the start as this would improve access, costs and quality
- The Medical Home strategy aligns the system brand promise of personalized care with the care delivery model.
- Medical Home differentiates Affinity Medical Group from other strong healthcare systems in our region by being first to market.

The Challenges

- Cultural paradigm shift
- Alignment of 100 PCP for support of this vision and a compensation structure that will continue to drive the outcomes.
- Geographic and Silo Issues: Implement 23 Medical Homes in a 50 mile radius.
- Affinity Medical Group Leadership transition left us without a champion

Hoshin Process
(must do, can't fail)

Hoshin Process

- Hoshin Process within Affinity: aligns leadership support and resources from the system
- LEAN methodology – improve processes, eliminate waste
- Pilots demonstrated success. Then through Hoshin process developed several 3-month plans to guide our implementation across the system
  - No project manager utilized – ownership of process at each department, yet system standardization
- Core Team – development and directional

Structure and Function

- Leader Champion – President AMG
- Core Team:
  - President, COO, Director of Medical Operations (DMO), Marketing, Physicians, Network Health Plan (NHP), Director of Clinical Operations (DCO)
- Coordination Team:
  - DCO, President, LEAN Coach – team that makes the work happen
- Site based MH Teams:
  - Physician/Advanced Practice Provider (APP) Leadership, RN Specialists, Healthcare Associate (HCA), Patient Service Representative (PSR), Behavioral Health Coordinator, Mgmt
- LEAN methodology to address flows

Team Roles

Physician & APP

- Physician:
  - Provides overall leadership to the team
    - Retains PCP role--in collaboration with other team members
    - Overall accountability for performance of practice relative to attributes of Medical Home, related measures of success
- Advanced Practice Providers – APP (APNP/PA):
  - Leadership role in patient education
    - Retains PCP Role—in collaboration with other team members
    - Shares team accountability for Wellness/ Disease/ Population Mgt.

RN Specialists

- RN Specialist:
  - Leadership Role in Wellness & Disease Management, Population Management, Health Coaching
    - Chronic disease management
      - Coordinates implementation of disease management registries and other population management tools
    - Participates in direct patient care
      - Collaborative visits for Wellness & Disease Management
      - Acute care visits (protocol directed and/or collaborative)
      - Chronic disease follow-up (blood pressure checks, ADHD)
    - Phone follow-ups

Behavioral Health Coordinator

- Behavioral Health Care Coordinator:
  - Leadership role in psychosocial support of patients & team
    - Position(s) selected by team based on practice needs
    - Care Coordinator (LCSW)/Behavior Health Coordinator (MSW)/Behavioral Health Specialist (PhD)
    - Range of services:
      - Care management
      - Psycho-social assessments, counseling & group work
      - Patient advocacy, liaison to community resources
      - *Provision of social support to team*

Health Care Associate

- Health Care Associate (HCA): (LPN/MA)
  - Leadership role in workflow management
    - Rooms patients but role in initiating care is expanded via medication reconciliation,

      "paperwork control," clinical protocols, and advanced intake tools
    - Key support role in access management
    - Team Nursing

Patient Service Representative

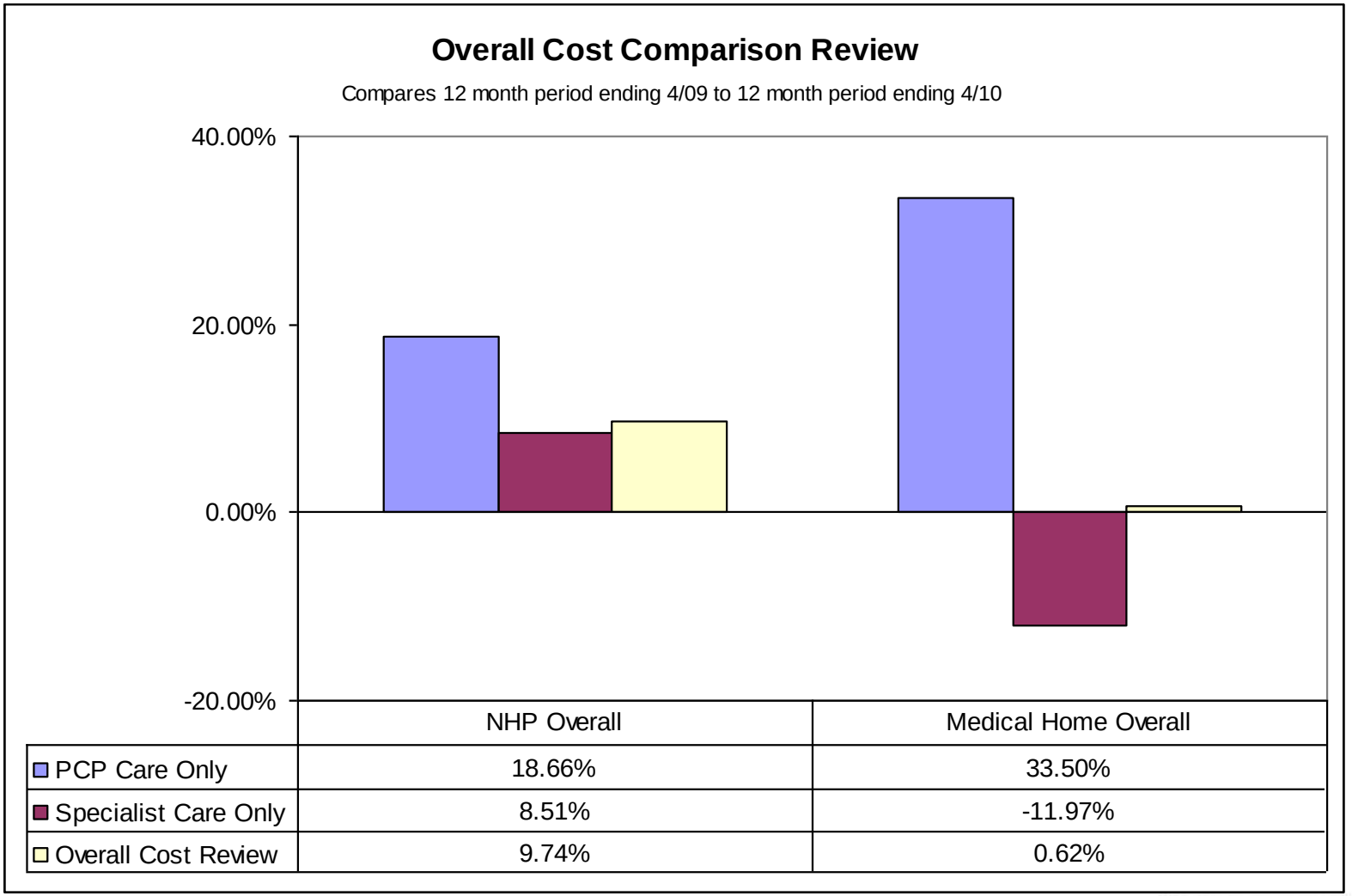
- Patient Service Representative (PSR):
  - Leadership role in Service Excellence & relationship management
    - Access management and coordination
    - Visit preparation

Network Health Plan Partnership

Insurance Plan

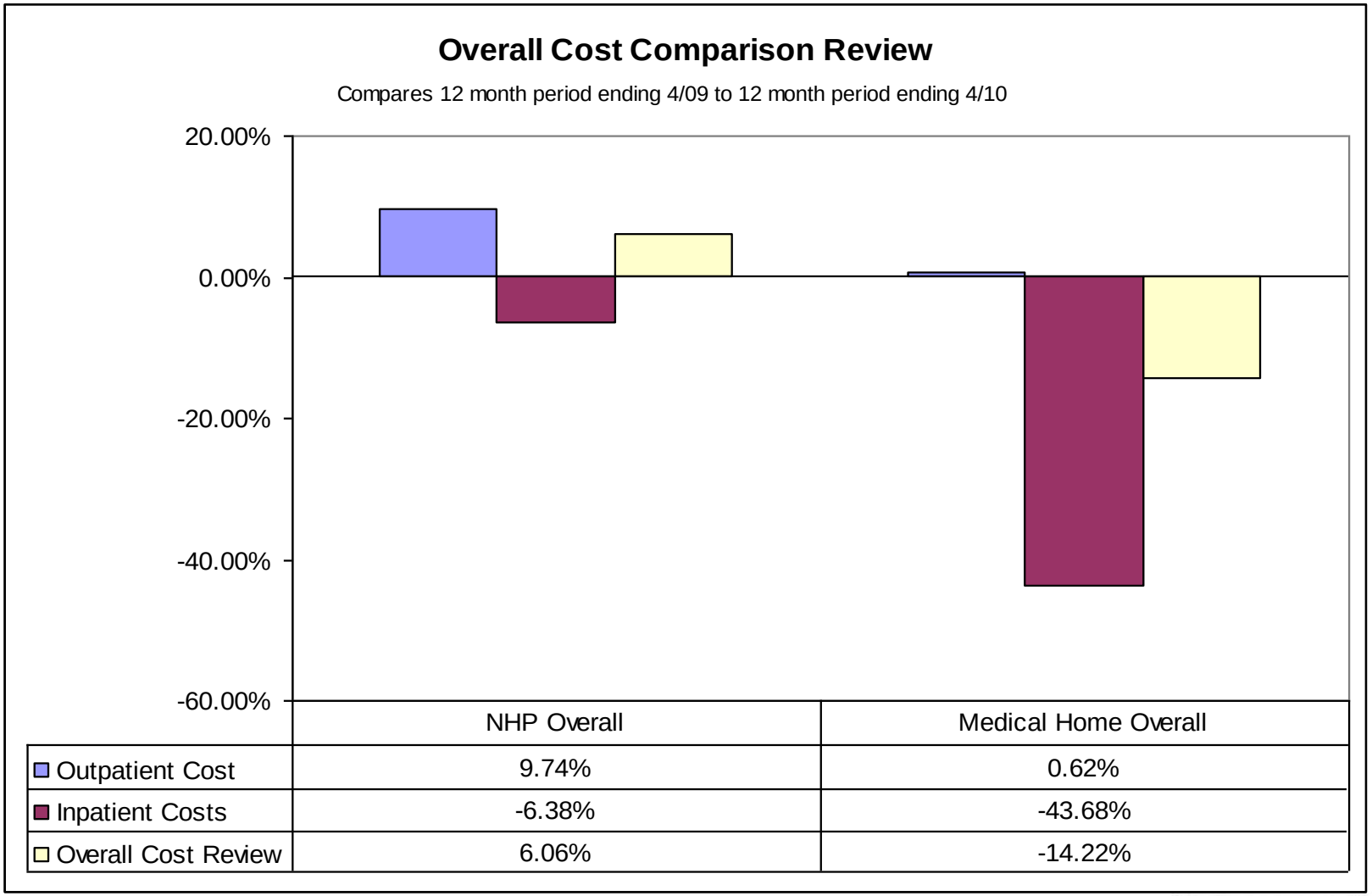
- Pilot support: $8PMPM
- Second year: Must implement and move to NCQA accredited
- Advantage of being able to get cost data on the care we provide to patients

AMH Outcomes: Cost



	NHP Overall	Medical Home Overall
PCP Care Only	18.66%	33.50%
Specialist Care Only	8.51%	-11.97%
Overall Cost Review	9.74%	0.62%

AMH Outcomes: Cost



	NHP Overall	Medical Home Overall
Outpatient Cost	9.74%	0.62%
Inpatient Costs	-6.38%	-43.68%
Overall Cost Review	6.06%	-14.22%

Full Implementation

- Health plan agreed to extend the $8PMPM to all practices.
- Move to a shared risk reimbursement model.
- Integration of health plan data (claims) into the ambulatory electronic record

Physician Compensation

Compensation

- Provider compensation – first year guarantee to facilitate meeting attendance and movement to team based care model.
- Physician involvement to develop compensation plan going forward
  - Implementation October 1, 2011
  - Rewards:
    - Quality, access, panel size, patient satisfaction, medical coordination, management of cost as well as production

Next Steps, Lessons Learned and Future Development

Lessons Learned

- Change management
  - Start from scratch?
- RN Specialists:
  - Thought they would be more case management
  - Weekly group meetings
- Provider engagement
  - Champion, Compensation, team development, interviewing, leadership training, collaborative across sites.
- Team Development
  - Behavioral based interviewing
  - Huddles
  - Role of Behavioral Health Coordinator

Future Development

- Medical Neighborhood
  - Integrative Medicine
  - Diabetic Education
  - Lipids
  - COPD
  - Vascular Screening
  - Physical Therapy
- Primary Care Innovation to continue redesign work
- Evaluate impact of compensation model

Next Steps

- Imbed Case Manager from Health Plan
- Implement on-going audits to assure maintenance of processes and NCQA standards
- Implement new compensation plan (Oct 1)
- Implement shared risk model of reimbursement (Jan 1)

Affinity Medical Home

- Questions?