The Medical Neighborhood: Delivering the Value

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The “health” system of yesterday

- Owner of disease/organ
- Member
- Consumer
- "Employee"

Patient

- Sub-specialty care
- Hospitals
- “Medical Neighborhood”

"Sick Care System"

Where the patient hangs out

- First contact care
- Comprehensive
- Continuous
- Compassionate

The gateway to the sick system

- Family
- Work
- School
- Community
Feeling healthy is the goal – not just more care

What Makes Us Healthy
- Genetics: 20%
- Environment: 20%
- Healthy Behaviors: 50%
- Access to Care: 10%

What We Spend On Being Healthy
- Medical Services: 88%
- Healthy Behaviors: 4%
- Other: 8%
Overall Goal: *Health system* transformation

- **Delivery Reform**
- **Payment Reform & Benefit Redesign**
- **Trained Health Work Force**
- **Public Engagement**
Painting the Vision: Need for New Paradigm

Current Health Care System

- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial
- “Everyone For Themselves”

Future with PCMH Implementation

- Managing Populations
- Collaborative Care
- Primary Care Driven
- Integrated eHealth Records
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative
- Joint Contracting
Defining the Patient-Centered Medical Home

The medical home is an _approach_ to primary care that is:

- **Person-Centered**
  - Supports patients and families in managing decisions and care plans

- **Comprehensive**
  - Whole-person care provided by a team

- **Coordinated**
  - Care is organized across the ‘medical neighborhood’

- **Committed to Quality and Safety**
  - Maximizes use of health IT, decision support and other tools

- **Accessible**
  - Care is delivered with short waiting times, 24/7 access and extended in-person hours

Source: www.ahrq.gov
PCMH as part of larger whole
Putting the Pieces Together, What makes a PCMH possible?

- Health Benefits Redesign
- Care Teams
- Community Linkages & Support
- Care Coordination
- Personalized Care Plans
- Patient & Family Engagement
- Behavioral Health Integration
- Integration into Medical Neighborhood
- Medication Management
- Continuous Quality Improvement
- Tech Assistance & Transformation Support
- eHealth & IT Infrastructure
- Trained Interprofessional Workforce
- Payment Reform
- Cultural Competency
- Health Coaching
- Community Linkages & Support
- Care Coordination
- Care Teams
- Health Benefits Redesign
- Personalized Care Plans
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- Behavioral Health Integration
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Primary care practices heading toward a “tipping point” of widespread patient-centered medical home (PCMH) adoption & growing evidence that model improves care to achieve the Triple Aim

Commercial plans, Medicaid, some employers, and now Medicare are increasingly paying for PCMH level care, despite broad variation in PCMH definition and implementation

Although patients & families want patient-centered care, they don’t know what PCMH means. Employers and health plans support idea but need a way to ensure practices have transformed to this model
Outcomes of Advanced Primary Care

- Cost Savings
- Fewer ED/Hospital Visits
- Improved Access
- Increased Preventive Services
- Improved Health
- Improved Patient & Clinician Satisfaction

Mapping Primary Care Innovations


Map of PCMH initiatives with reported outcomes
Pennsylvania Chronic Care Initiative (PA-CCI)

Program:
- Multi-Payer program
- Began in 2009, rolled out in 4 regions
- Region implementation varied in payment model (i.e. opportunity for shared savings), practice size, patient population

2015 Results:
- *JAMA Internal Medicine*, June 2015
- Evaluation of Northeast region, evaluated pilot practices after 3 years of implementation

Study found lower rates of:
- all-cause hospitalization (-1.7)
- all-cause ED visits (-4.7)
- ambulatory-care sensitive ED visits (-3.2)
- ambulatory visits for specialists (-17.3)

- higher performance in all 4 examined measures of diabetes care quality
- higher rates of ambulatory primary care visits (+77.5) per 1000 patients per month
Michigan Blue Cross Blue Shield Physician Group
Incentive Program

PCMH Strategies:
- Patient registries to track and monitor patients’ care
- 24-hour patient access through extended office hours, telephone access, and linkage to urgent care
- Opportunity to earn enhanced reimbursement (tied to performance)

2015 Results:

Health Affairs, April 2015
- PCMH practices decreased total PMPM spending by $4.00 more than control practices
- PCMH providers spent $5.44 less PMPM for pediatric patients, a savings of 5.1%
- PCMH practices performed better or equally on 11 of 14 quality measures
- Statistically significant improvement in 3 of 7 quality measures for preventive care

Blue Cross Blue Shield Press Release, July 2015
- Program has saved an estimated $512 million over 6 years
- 26% lower rate of hospital admissions for common conditions
- 10.9% lower rate of adult ER visits; 16.3% lower rate of pediatric ER visits
- 22.4% lower rate of pediatric ER visits for common chronic and acute conditions (i.e. asthma)
CareFirst Blue Cross Blue Shield PCMH Program (Maryland-Virginia-DC)

PCMH Strategies:

- Use local care coordination teams to track high-risk members
- Create an infrastructure for nursing support, easily-accessible online tools and data, and targeted health programs
- Organize primary care providers (PCPs) into panels – groups of 5 to 15 physicians – to coordinate the care of members
- Offer increased reimbursements to physicians based on performance

2015 Results:

- CareFirst Industry Report, July 2015
- Since 2011, medical costs for PCMH members have been $609 million less than expected, $345 million less than projected in 2014 alone
- ~84% of provider panels earned Outcome Incentive Awards (OIA) - an avg. of $41,000 - $49,000 in increased revenue

Since the program began in 2011, PCMH members have had*:

- 19% fewer hospital admissions
- 15% fewer days in the hospital
- 20% fewer hospital readmissions for all causes
- 5% fewer outpatient health facility visits
Comprehensive Primary Care (CPC) Initiative

Program:
- Federally funded multi-payer PCMH program implemented in 7 regions
- 5 functions:
  - Risk-stratified Care Management
  - Access and Continuity
  - Planned Care for Chronic Conditions and Preventive Care
  - Patient and Caregiver Engagement
  - Coordination of Care across the Medical Neighborhood
- Offers population-based care management fees and shared savings opportunities

2015 Results:
- Mathematica evaluation, January 2015
- Evaluation of program year 1

- Across the 7 regions, reduced Part A and Part B expenditures per beneficiary by $14 or (2%)
  - Reductions are relative to a matched comparison group and do not include the care management fees (~$20 per beneficiary per month)

- CPC generated reductions in hospitalizations, outpatient ED visits, primary care physician visits, and specialist visits
- Sizable (4%) CPC-wide decline in unplanned 30-day readmissions
- **2% reduction in hospital admissions and 3% reduction in ED visits**, which nearly offset care management fees paid by CMS
The Collaborative: What We Do

Our Vision
• The achievement of an effective and efficient US health system built on a strong foundation of primary care and the patient-centered medical home (PCMH).

Our Mission
• To be a key driver of the growing national primary care movement by:
  – Convening diverse health care stakeholders to promote learning, awareness, and innovation
  – Disseminating results and outcomes from advanced primary care and PCMH initiatives
  – Educating stakeholders and strengthening public and private sector policies that improve the US health system for patients, providers, and payers
Our Goal: Unify Diverse Perspectives

Public: Patients, Families, Caregivers, Consumers

Payers: Employees, Employers, Health plans, Government, Policymakers

Providers: Primary care team, specialists, community orgs

What does alignment across interests look like?
Clarifying “PCMH” – What is it?

Is it a “Good Housekeeping” Seal of Approval for the Public?

Is it a quality improvement process for practices?

Is it a recognition or certification process for payers and purchasers?

Is it a payment model for government and/or commercial plans?
PCMH as a “certification”

• External validation
• “Short term” view of model
• Focused more on process measures
• Role in practice transformation & increased reimbursement
• Role in assessing value by payers

PCMH as ideal of practice transformation

• “North star” – aspirational guide
• “Long term” view of model
• Focused more on outcomes
• What’s most important to patients, families, caregivers & consumers?
Primary Care Practice “Journey”

1. Laying the Foundation
   - Engaged Leadership

2. Building Relationships
   - Empanelment
   - Continuous and Team-Based Healing Relationships

3. Changing Care Delivery
   - Organized, Evidence-Based Care
   - Patient-Centered Interactions

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination

http://www.safetynetmedicalhome.org/resources-tools/all-resources
Patient & Family Perspective: Engagement Framework

Continuum of engagement

Levels of engagement

Direct care

Consultation
Patients receive information about a diagnosis

Involvement
Patients are asked about their preferences in treatment plan

Partnership and shared leadership
Treatment decisions are made based on patients’ preferences, medical evidence, and clinical judgment

Organizational design and governance

Consultation
Organization surveys patients about their care experiences

Involvement
Hospital involves patients as advisers or advisory council members

Partnership and shared leadership
Patients co-lead hospital safety and quality improvement committees

Policy making

Consultation
Public agency conducts focus groups with patients to ask opinions about a health care issue

Involvement
Patients’ recommendations about research priorities are used by public agency to make funding decisions

Partnership and shared leadership
Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:

- Patient (beliefs about patient role, health literacy, education)
- Organization (policies and practices, culture)
- Society (social norms, regulations, policy)

Source: Carman, Dardess, Maurer, Sofaer, Adams, Bechtel, Sweeney (2013) Health Affairs
Getting employers & health plans engaged

Employers knowing their workforce, engaging and educating employees in their own health – where they live, work, and play (mHealth tools, & population health strategies)

Employers, health plans, and providers developing contracts that incentivize value (demand and supply side) to drive down total cost of care and improve population health

Linking to multi-payers initiatives in your local region/state to promote alignments in payment & push for reform
Building Blocks: Trajectory to Value-Based Purchasing

HIT Infrastructure: EHRs and population health management tools

Primary Care Capacity: PCMH or advanced primary care

Care Coordination: Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/Outcome Measurement: Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing: Reimbursement tied to performance on value

Alternative Payment Models (APMs): ACOs, PCMH, & other value based arrangements

Source: THINC - Taconic Health Information Network and Community
Payment Reform:
Moving Medicare FFS payments to quality and alternative payment models

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 30% All Medicare FFS (Categories 1-4)
- 85% FFS linked to quality (Categories 2-4)
- 5% Alternative payment models (Categories 3-4)

2018
- 50% All Medicare FFS (Categories 1-4)
- 90% FFS linked to quality (Categories 2-4)
- 10% Alternative payment models (Categories 3-4)

Source: CMS
Current Primary Care Investment

U.S. per-capita health spending, 2012 (under 65 with employer-sponsored health insurance)

Next up: Need for Behavioral Health Integration

- Mental Illness vs. No Mental Illness
  - High Blood Pressure: 21.9% vs. 18.8%
  - Smoking: 36% vs. 21%
  - Heart Disease: 5.9% vs. 4.2%
  - Diabetes: 7.9% vs. 6.6%
  - Obesity: 42% vs. 35%
  - Asthma: 15.7% vs. 10.6%
And shift from individuals to populations
The “health” system of tomorrow

- First contact care
- Comprehensive
- Continuous
- Compassionate

- Sub-specialty care
- Hospitals
- “Medical Neighborhood”

- Patient
- Consumer
- Member
- “Employee”

- Family/caregivers
- Work/School
- Community Orgs
- Faith-based Orgs

- Primary Care or PCMH
- Accountable Care

- Person
- Community
Q&A