

The Patient-Centered Medical Home: Implications for Employers

Rhode Island Business Group on Health
Annual Meeting: September 16, 2010

Deidre S. Gifford, MD, MPH
Project Director
Rhode Island Chronic Care Sustainability
Initiative



Overview

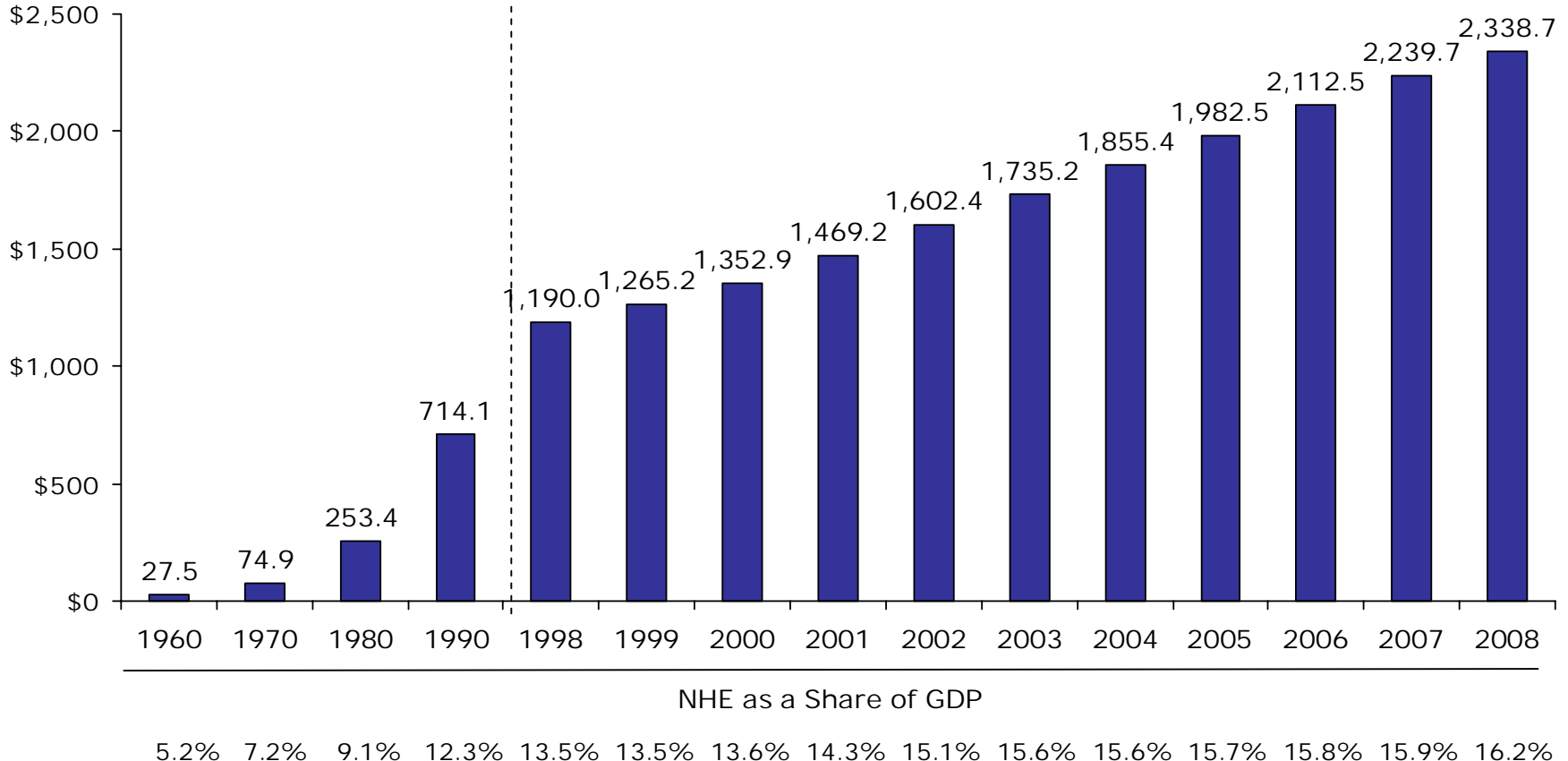
- Why talk about Medical Homes now?
- What is the Medical Home, and how will it address our current delivery system problems?
- How do we measure the Medical Home?
- The RI Chronic Care Sustainability Initiative: A multi-payer PCMH program
- Q and A

What problems are we trying to address with the Medical Home?

- High costs
 - Ambulatory care of Chronic Disease
 - Unnecessary hospital admissions and re-admissions
 - Specialty care
 - Inappropriate Emergency Department use
- Gaps in quality of care
 - Lack of care coordination/fragmentation
 - Restricted access to care
 - Adherence to evidence-based guidelines
- Primary care workforce crisis
- Absence of the patients' views/needs in current system

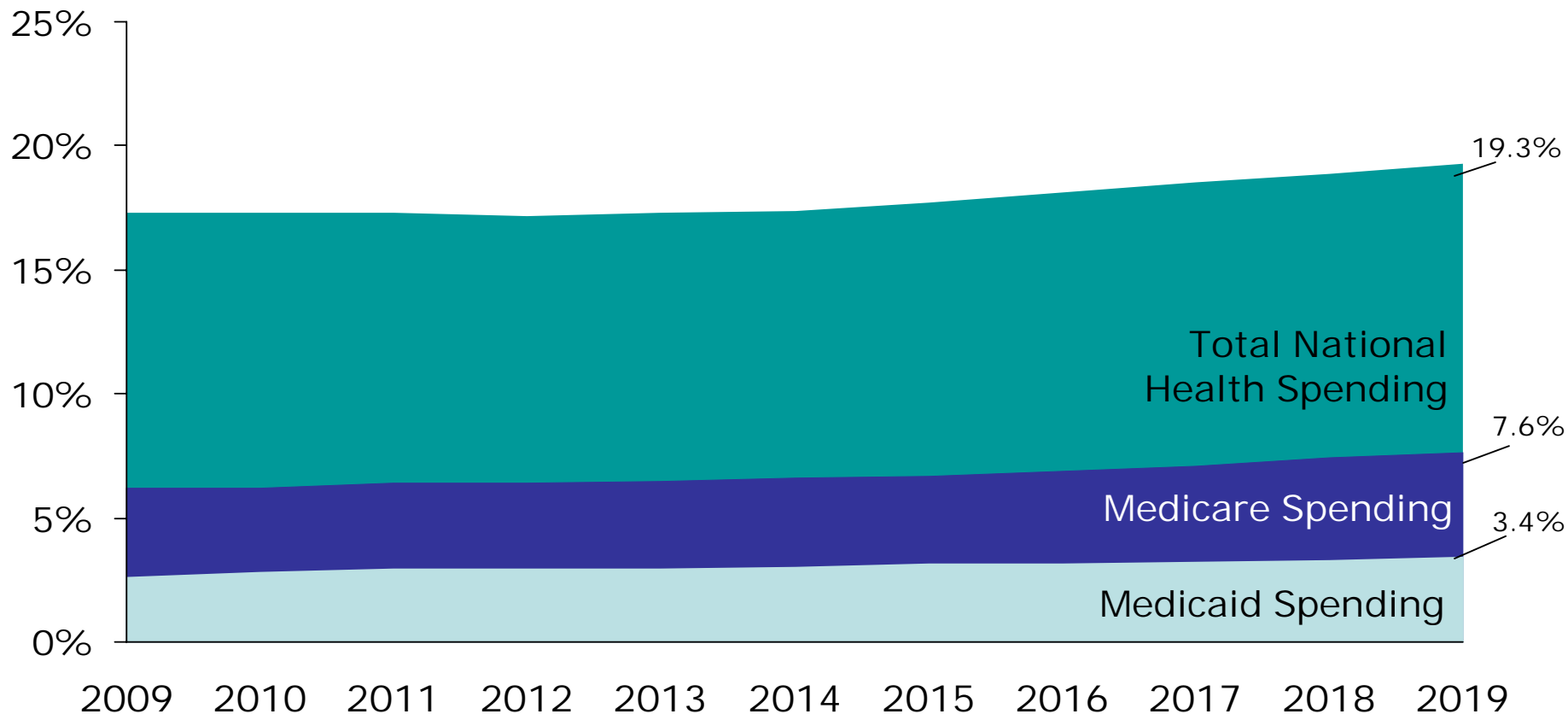
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2008

Dollars in Billions:



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2008; file nhegdp08.zip).

Projected Spending on Health Care as a Percentage of Gross Domestic Product

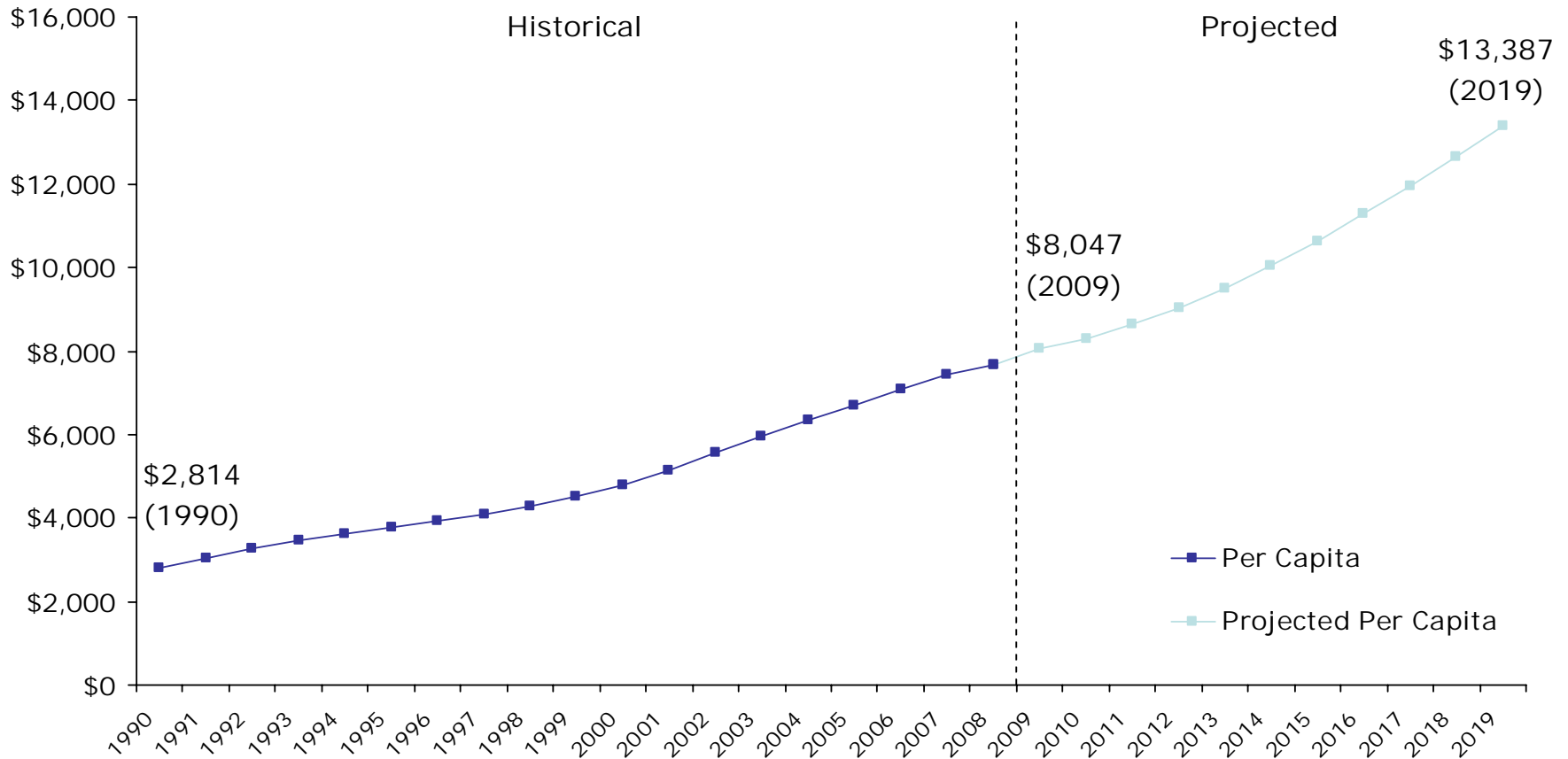


Total NHE:
(in billions)

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total NHE	\$2,472	\$2,570	\$2,703	\$2,850	\$3,025	\$3,225	\$3,442	\$3,684	\$3,936	\$4,204	\$4,483

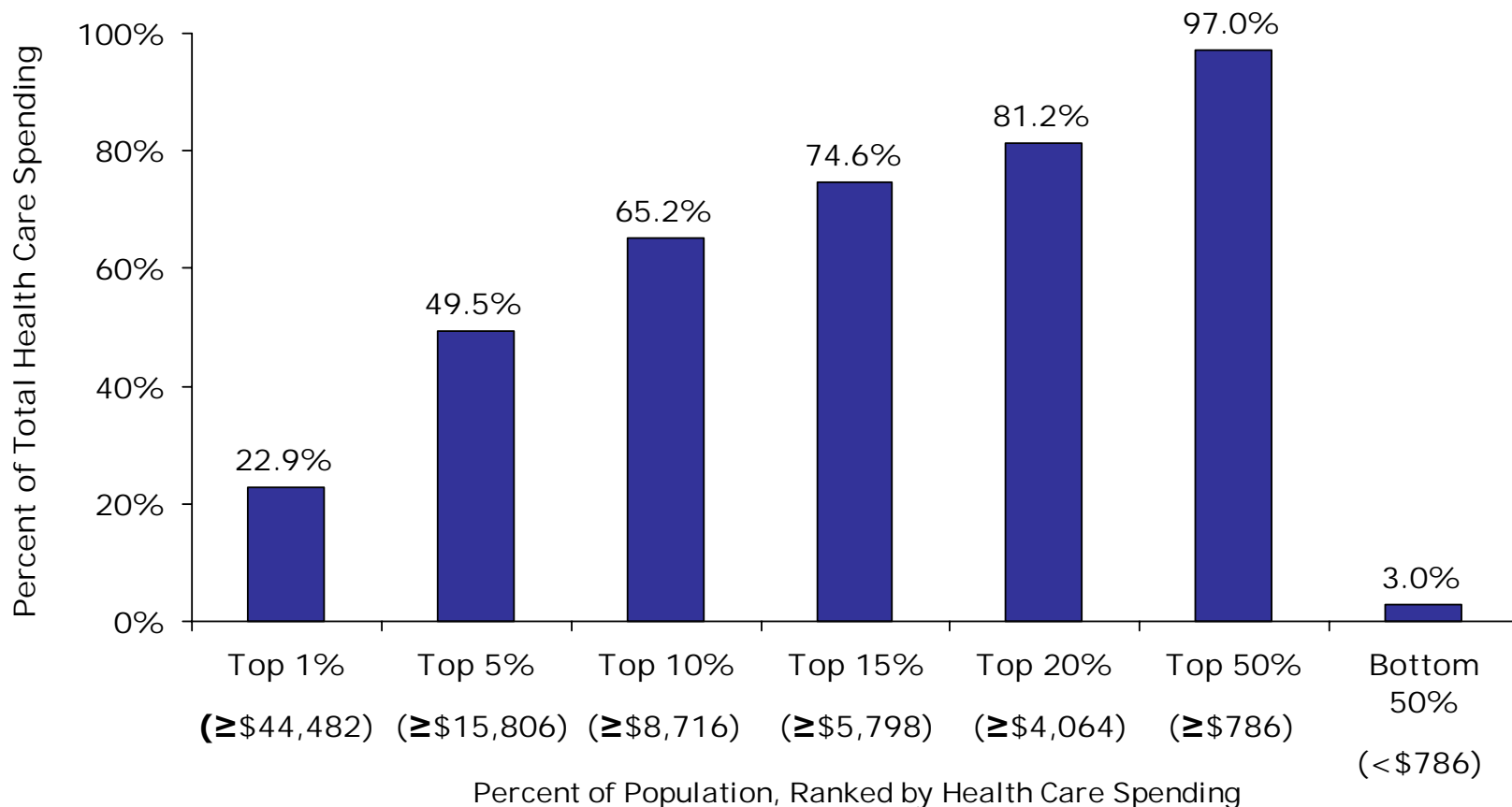
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage (see Projected; NHE Historical and projections, 1965-2019, file nhe65-19.zip).

National Health Expenditures Per Capita, 1990-2019



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (Historical data from NHE summary including share of GDP, CY 1960-2008, file nhegdp08.zip; Projected data from NHE Projections 2009-2019, Forecast summary and selected tables, file proj2009.pdf).

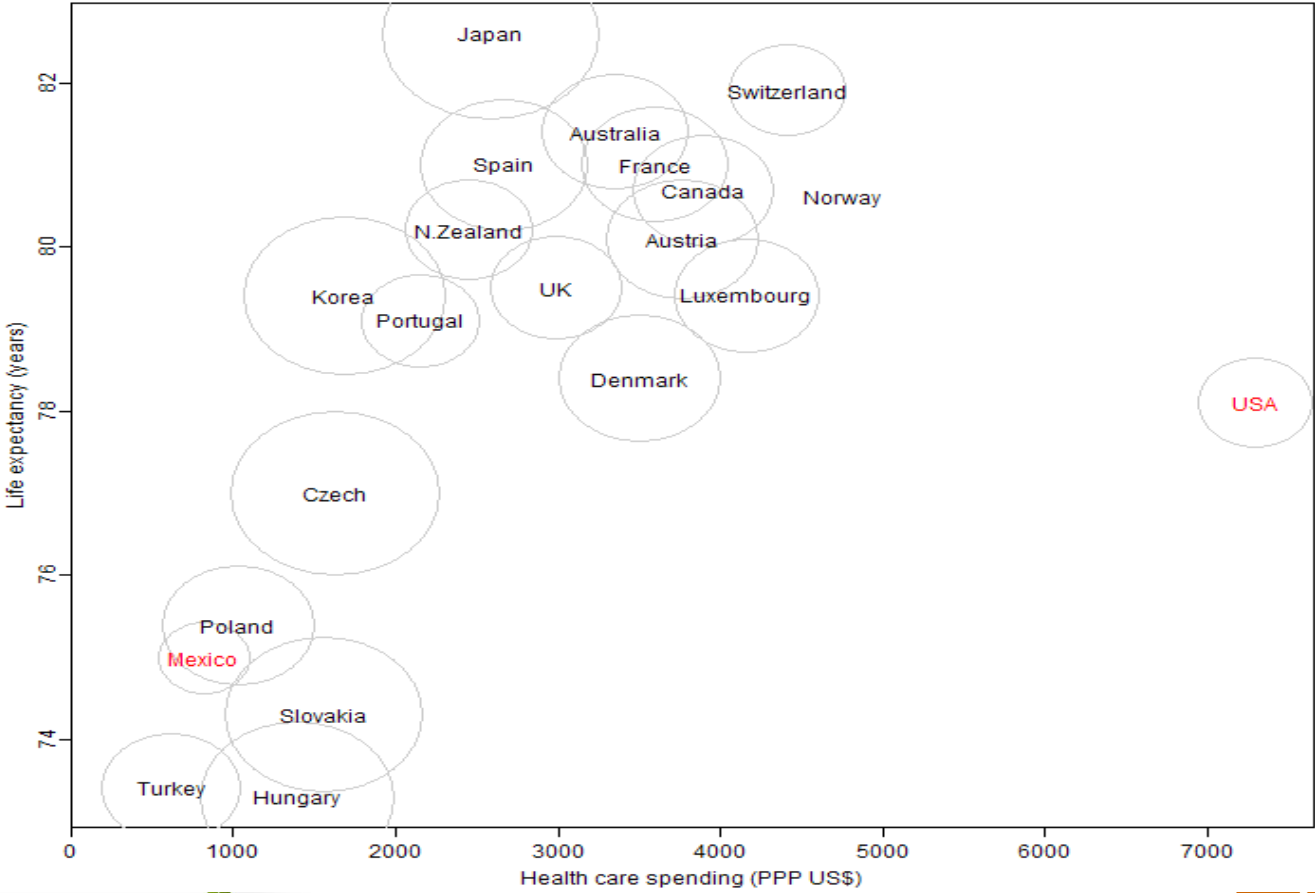
Concentration of Health Care Spending in the U.S. Population, 2007



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2007.

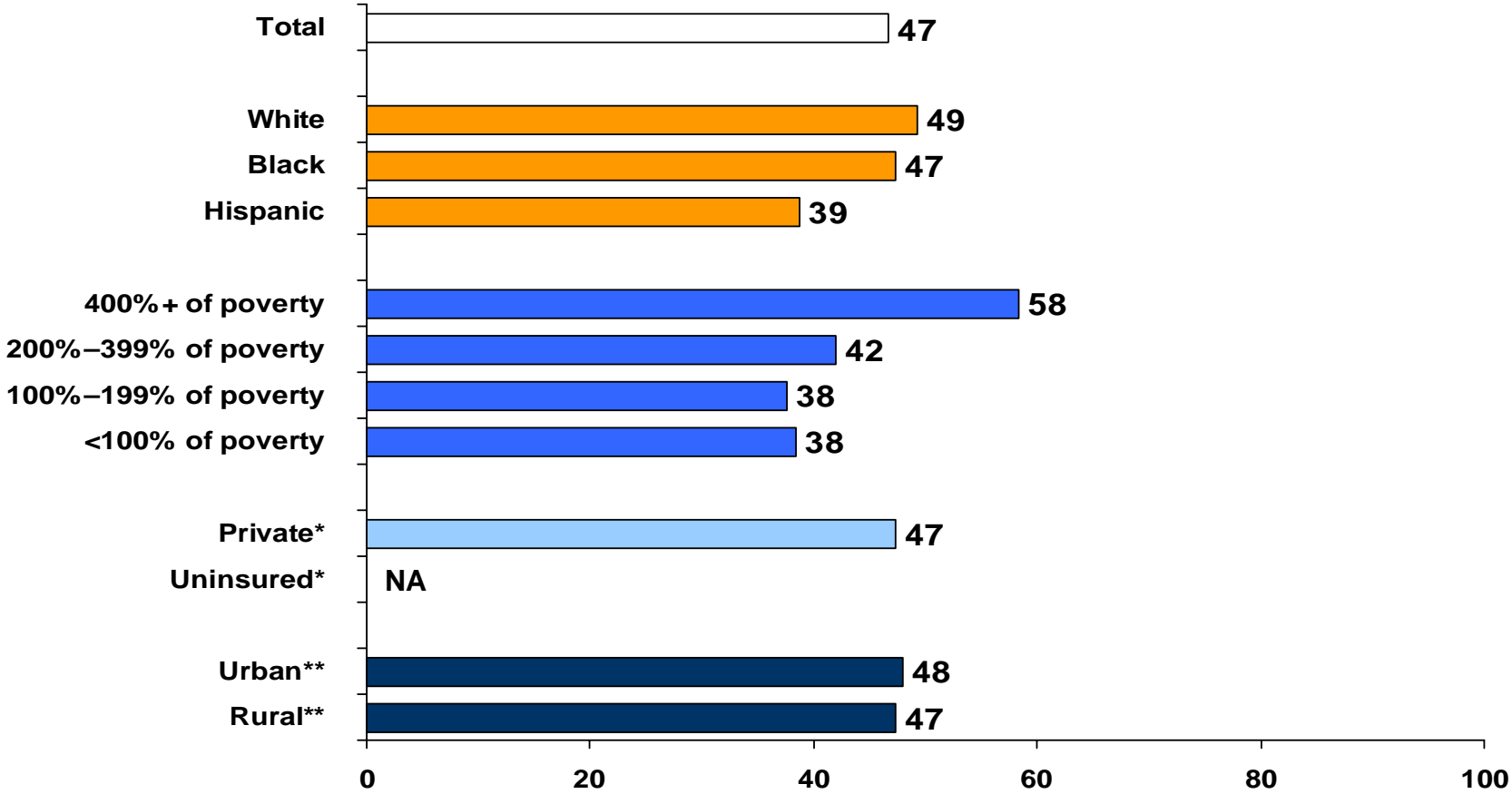
Health Care Spending vs. Life Expectancy



EQUITY: EFFECTIVE CARE

Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity, Family Income, Insurance, and Residence, 2004.

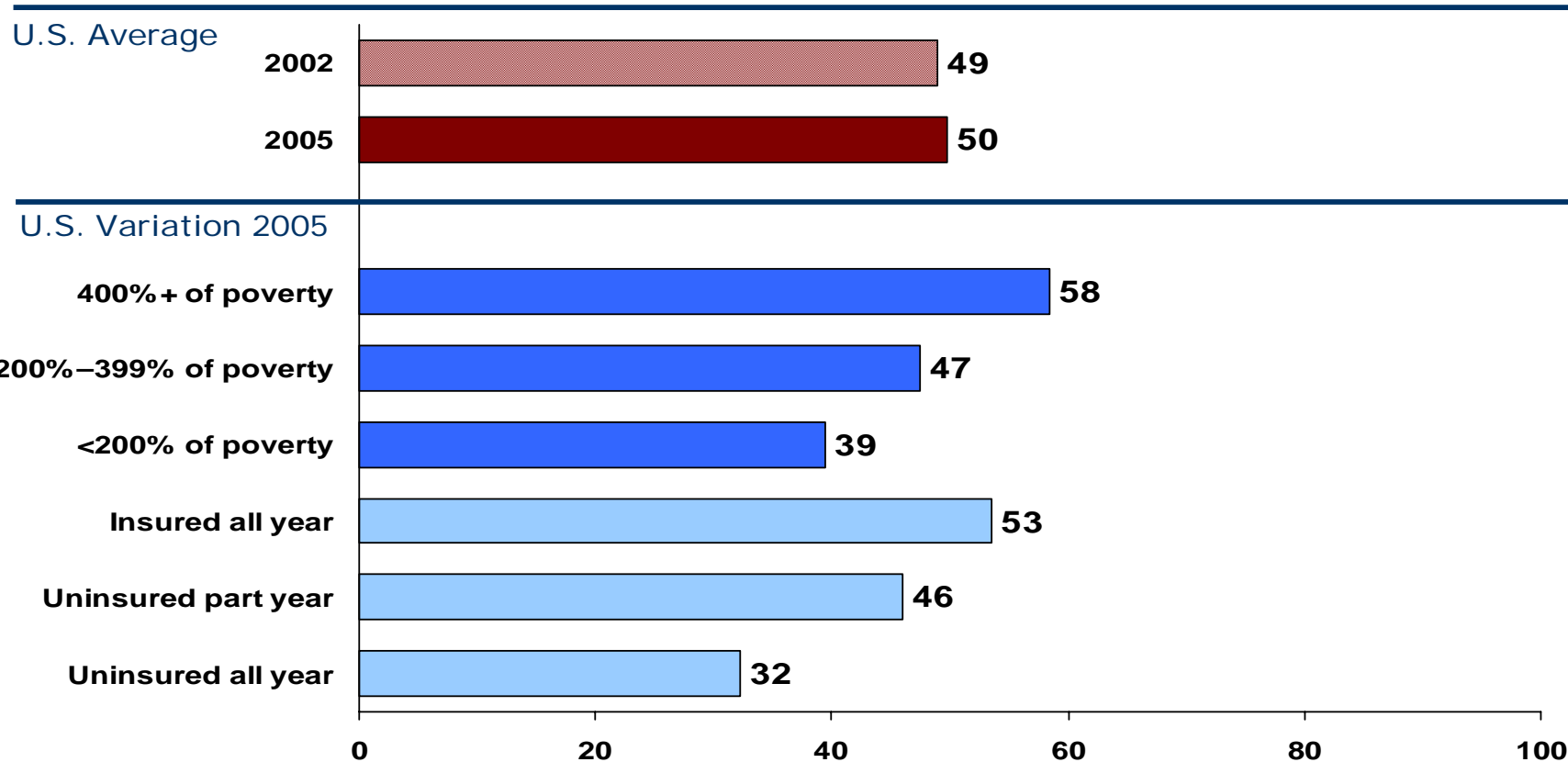
Percent of diabetics (ages 40+) who received HbA1c test, retinal exam, and foot exam in past year



*Insurance for people ages 40–64. ** Urban refers to metropolitan area ≥ 1 million inhabitants; Rural refers to noncore area $< 10,000$ inhabitants. NA=data not available.
Data: Medical Expenditure Panel Survey (AHRQ 2007a).

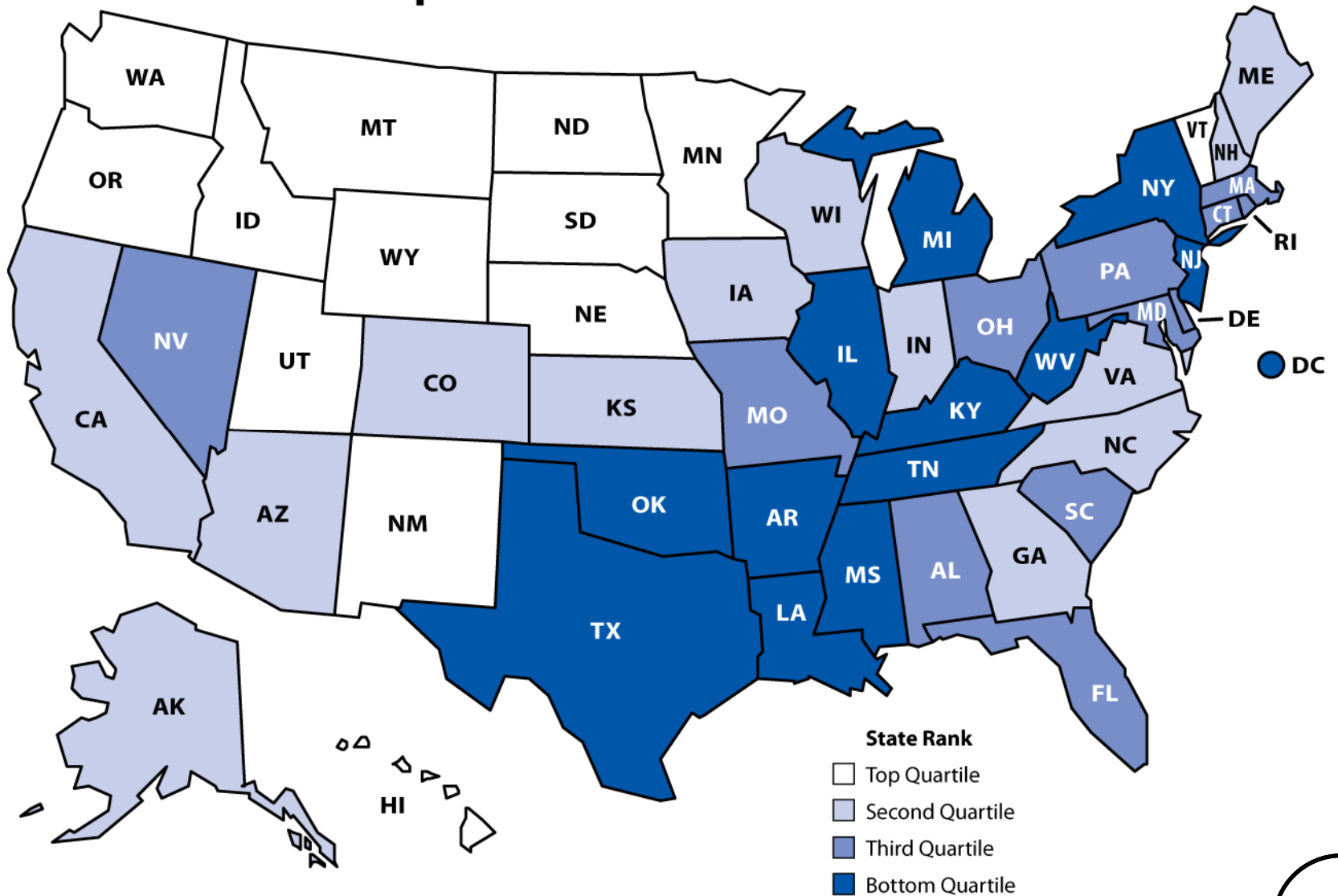
Receipt of Recommended Screening and Preventive Care for Adults

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. See report Appendix B for complete description.
 Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension

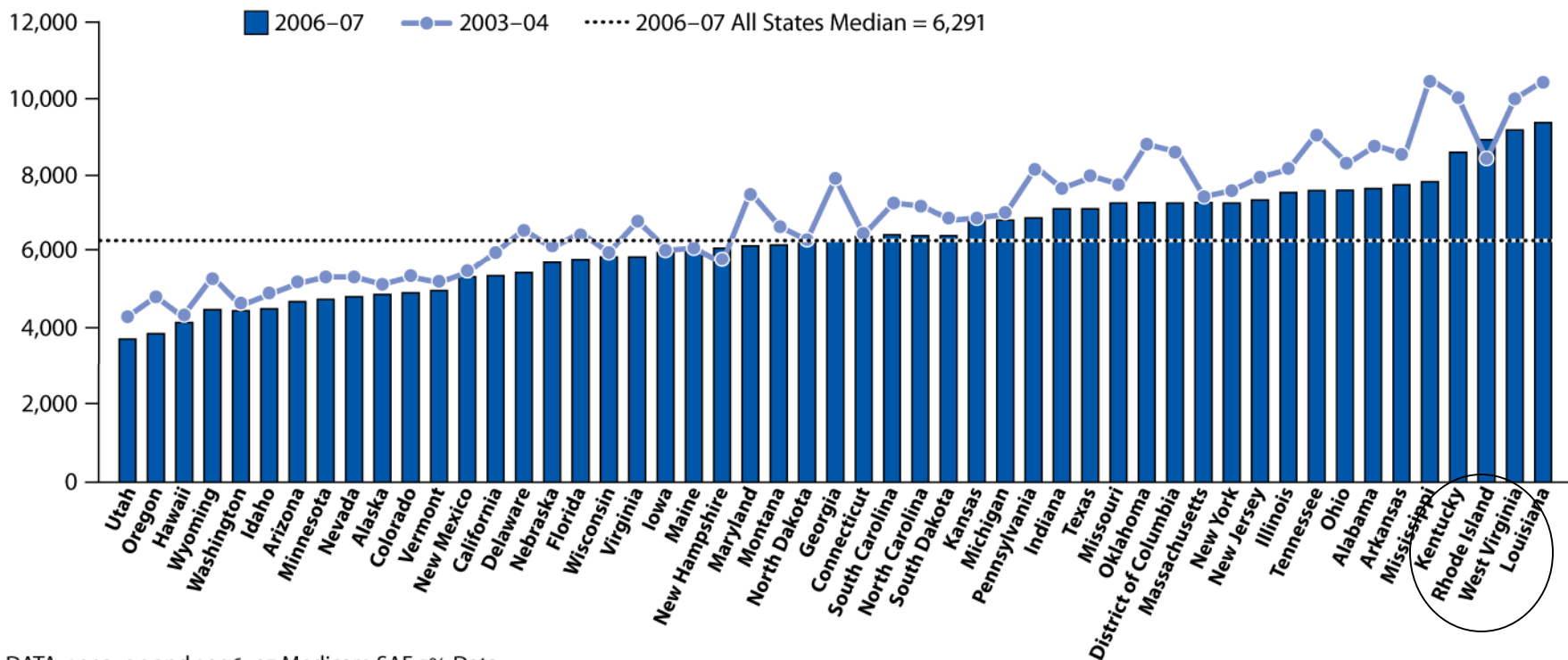


SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009



State Rates of Hospital Admissions for Ambulatory Care Sensitive Conditions Among Medicare Beneficiaries

Admissions per 100,000 beneficiaries



DATA: 2003-04 and 2006-07 Medicare SAF 5% Data

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009



The Problem: cont.

- Limitations: 50 percent of patients leave primary care visits not understanding what they were told by the physician
 - » Bodenheimer, et al Health Affairs 28, no. 1 (2009): 64–74

What is the Medical Home, and why is it part of the solution?

- Primary care

- "The availability of primary care is positively and consistently associated with improved outcomes, reduced mortality, lower utilization of health care resources, and lower overall costs of care."

- » How Is a Shortage of Primary Care Physicians Affecting the Quality and cost of Medical Care? American College of Physicians; November 2008: White Paper

Elements of the Medical Home

Joint Principles of the Patient-Centered Medical Home –
February, 2007

- Whole person orientation
- Personal physician
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access to care
- Payment to support the PC-MH
- Team care
- Emphasis on patient engagement and self-management

How is a “Medical Home” different from usual care?

- The ideal Medical Home will:
 - Be responsible for coordinating all of a person’s care (specialists, hospitals, home health, etc.)
 - Measure and monitor the quality and safety of care
 - Ask patients if they are satisfied
 - Provide enhanced access to care, such as nights, week-ends, e-mail and easier phone contact

The Ideal Medical Home will:

- Use technology to improve quality and patient experience (e.g., ePrescribing, e-mail, automated scheduling, practice web-site, etc.)
- Use techniques and personnel to help patients manage their own illness, rather than simply giving instructions (“patient engagement”)
- Use teams of providers to help patients manage their illness, such as nutritionists, educators and behavioral specialists
- Focus on the “whole person,” not on specific diseases

How to recognize a Medical Home:

- Some state-based recognition/certification programs
- NCQA “Physician Practice Connections” (PPC-PCMH)
 - Levels 1 – 3
 - 10 “must pass” elements
 - Some believe too tech-centered
 - ?Patient centered

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts	Standard 5: Electronic Prescribing	Pts
A. Has written standards for patient access and patient communication**	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication**	5	B. Has electronic prescription writer with safety checks	3
	9	C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	Pts		8
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	Pts
B. Has clinical data system with clinical data in searchable data fields	3	A. Tracks tests and identifies abnormal results systematically**	7
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
D. Uses paper or electronic-based charting tools to organize clinical information**	6		13
E. Uses data to identify important diagnoses and conditions in practice**	4	Standard 7: Referral Tracking	PT
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	A. Tracks referrals using paper-based or electronic system**	4
	21		4
Standard 3: Care Management	Pts	Standard 8: Performance Reporting and Improvement	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3	A. Measures clinical and/or service performance by physician or across the practice**	3
B. Generates reminders about preventive services for clinicians	4	B. Survey of patients' care experience	3
C. Uses non-physician staff to manage patient care	3	C. Reports performance across the practice or by physician **	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	D. Sets goals and takes action to improve performance	3
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5	E. Produces reports using standardized measures	2
	20	F. Transmits reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	Pts		15
A. Assesses language preference and other communication barriers	2	Standard 9: Advanced Electronic Communications	Pts
B. Actively supports patient self-management**	4	A. Availability of Interactive Website	1
	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	1
			4

****Must Pass Elements**

Will the Medical Home reduce costs or improve quality?

- Formal evaluations (such as RIs) are in early stages
- Group Health and HealthPartners have seen ~30% reduction in ER visits
- Geisinger has seen 14% reduction in hospital admissions, and \$3.7 mil savings over 2 years (2 to 1 ROI) in 11 clinics
- Intermountain Healthcare had 10% reduction in hospitalizations, and \$640 per person per year savings

Early Findings: Group Health “prototype” clinics: 21 months

- 6% fewer outpatient visits
 - 80% more e-mail
 - 5% more telephone
- 29% fewer ED visits
- 6% fewer inpatient admissions
- Decreased staff burn-out
- Improved patient satisfaction

Reid et al, Health Affairs, May 2010

Early Findings: Group Health “prototype” clinics: 21 months

- Total costs:
 - \$10 less PMPM in prototype clinics
- Estimated ROI:
 - 1.5 : 1.0

Reid et al, Health Affairs, May 2010

Common Elements to Decrease Costs and Increase Quality

- Dedicated non-physician care coordinator
- Expanded Access to Providers
- Real time data to Manage Performance and Track Patients
- Effective Incentive Payments

Fields et al, Health Affairs, May 2010

Genesis of The RI Chronic Care Sustainability Initiative: A multi-payer demonstration of the Medical Home

- National
- State interest in primary care sustainability:
 - Governor's initiative in "balanced healthcare"
 - Medicaid interest in developing primary care infrastructure and reducing costs for chronic disease: PCCM model
 - Health Insurance Regulation includes affordability focus
- History of multi-stakeholder collaboration – "Line of site trust"
- Existing practice assistance infrastructure and chronic care improvement collaborative
- Funding Opportunity:
 - Center for Healthcare Strategies' "Regional Quality Initiative"

What is CSI Rhode Island?

- A statewide, multi-stakeholder collaborative effort designed to:
 - Align quality improvement goals and financial incentives among Rhode Island's health plans, purchasers and providers, in order to develop and support a sustainable model for the delivery of chronic illness care in primary care settings.
 - Enhance payment to primary care providers for the delivery of high quality chronic illness care and establishment of Medical Home" based on external standards.

CSI Oversight and Governance:

- Developed, implemented, monitored and governed by a statewide, multi-stakeholder collaborative
- Convened by Health Insurance Commissioner
- Collaborative includes payers, purchasers, providers, state, technical experts
- Convening infrastructure initially grant-funded, now funded by plans

Key Elements of Program: Oversight and Governance

- Conveners invited original participants (2006)
- Leaders from primary care community and largest employers invited to participate in collaborative
- Common Contract elements negotiated in public by collaborative
- Decisions by consensus with rare votes
- Transparency to build trust

Key Elements of Program: Participating Payers

- All commercial payers in Rhode Island
 - UHC New England
 - BCBS Rhode Island
 - Tufts Health Plan
- Medicaid FFS* and Managed Care
 - Neighborhood Health Plan of Rhode Island
- All commercial product lines, including Medicare Advantage and ASO
- In total: 67% of insured in RI

**some contract variations*

Participants in CSI Collaboration:

- Payers (representing 67% of insured residents)
 - Medicaid; all RI-based commercial payers (Blue Cross & Blue Shield of Rhode Island,, United HealthCare – New England, Tufts Health Plan) Neighborhood Health Plan of Rhode Island
- Purchasers (including 70,000 self-insured residents)
 - The two largest private sector employers (Care New England, Lifespan) Rhode Island Medicaid, State Employees - health benefits program, Rhode Island Business Group on Health
- Providers
 - Largest primary care provider organizations (including Community Health Centers and hospital based clinics), Rhode Island Medical Society, RI AAFP, RI ACP
- State
 - Office of the Health Insurance Commissioner, Department of Human Services, Department of Health
- Technical Experts
 - Department of Health; Quality Improvement Organization

Key Program Elements: Practices and Patients

	Phase 1: Oct. 2008 – Sept. 2010	Phase 2: April 2010 – March 2012	Total
Number of Practices	5	8	13
Number of Patients covered by PMPM	24,279	21,791	46,070
Total patients in pilot practices (includes estimated 35% FFS Medicare)	37,352	33,525	70,877
Number of Providers	28	35	63

Key program elements: Contracts

- Plan responsibilities:
 - Attribution of patients to practices
 - Pay \$3 PMPM for all members
 - Provide salary and benefits for Care Managers in practice
 - *Provide data and feedback on utilization*
 - Support project infrastructure

Key program elements: Contracts

- Practice responsibilities:
 - Achieve Level 1 NCQA recognition by 9 months into pilot
 - Level 2 NCQA by 18 months
 - *Report clinical quality measures from EMR/registry in 3 conditions beginning Q2 of pilot*
 - Participate in training collaborative
 - Hire and utilize nurse care manager

“Formal” Program Evaluation

- Meredith Rosenthal and colleagues, Harvard School of Public Health (*Funded by Commonwealth*)
 - Will look for evidence that:
 - Organizations providing care adopt components of the patient-centered medical home model (NCQA PPC-PCMH)
 - Intervention has an impact on patients, including changes in care processes, outcomes and experiences of care (claims and patient survey)
 - Intervention is associated with changes in the cost of care (claims)
 - Qualitative information on experience of PCMH adoption (professional staff surveys)

Key program elements: Clinical Conditions

- Based on RI – specific prevalence, cost and utilization
- Employer input
- Adults with:
 - Diabetes
 - Coronary artery disease
 - Depression

Key Program Elements: Collaborative Responsibilities

- Oversight:
 - Convene regular oversight meetings
 - Identify and engage stakeholders
 - Ensure communication between stakeholders
- Pilot program development and implementation:
 - Facilitate negotiations, propose compromises
 - Review contracts to ensure comparability across plans and practices
 - Allocate nurse care managers
- Ensure adequate program evaluation
 - Collect and distribute performance data
 - Liaison with outside evaluator
- Engage and ensure technical assistance for pilot sites
- Cheerlead, cajole, influence, etc. to move project forward
 - Plan for long term sustainability

CSI RI: Quarterly clinical measurement

- CAD
 - Beta blocker post-MI
 - Smokers advised to quit
- Diabetes
 - Hgb A1c < 7%
 - BP < 130/80
- Depression
 - % adults screened in measurement year

Quarterly utilization measures (by practice)

Inpatient (excluding mental health and substance abuse and maternity and delivery)

- Inpatient admissions per 1000
- Inpatient days per 1000
- Average inpatient length of stay
- Inpatient per person cost trend (compared to same quarter of previous year)

Inpatient mental health and substance abuse

- Inpatient admissions per 1000
- Inpatient days per 1000
- Average inpatient length of stay
- Inpatient per person cost trend (compared to same quarter of previous year)

ED Use

- ED visits per 1000
- # of members with multiple ED visits (within 90 days)
- ED per person cost trend (compared to same quarter of previous year)

Pharmacy

- % generic of total utilization

Outpatient specialty and primary care

- Primary care visits per 1000
- Specialty care visits per 1000
- Radiology procedures per 1000
- Behavioral health per 1000

Care Management Activities: CSI Nurse Care Manager

- Located within practices: *Provides services to ALL patients, regardless of payer*
- Provided through cash payments from health plans
- Care Manager “college:” Collaboration of NCMs across sites and with Medicaid NCMs
- Activities:
 - Initial patient assessment and risk stratify severity of chronic illnesses
 - Maintain registry/generate reports
 - Gather and maintain educational information
 - Education of patient on disease and treatment
 - Monitor quality measures
 - Access health plan resources

CSI Payment Model

- Current FFS model remains in place
- Monthly \$3 pmpm fee to each practice for enhanced PCMH services, plus cash to support Care Managers
- Plans and providers agree to attribution methodology
(commercial: claims based - any one with last visit to site in 2 year time period and member at end of period)
- No clinical performance incentives

Integrating hospitals

- Recently enrolled a hospital (South County Hospital) and 7 affiliated primary care practices in CSI
- Hospital serving as hub: convenes providers, provides technical assistance,
- Hospital will employ nurse care managers
- Will work to improve communication, IT infrastructure
- Will work to provide “ancillary” services such as education, counseling, pharmacy, etc.

Results!

- All 5 initial sites achieved NCQA recognition on time
- All sites successfully reporting quality measures
- NCMs hired, integrated and functioning with practices
- 1st year collaborative training completed

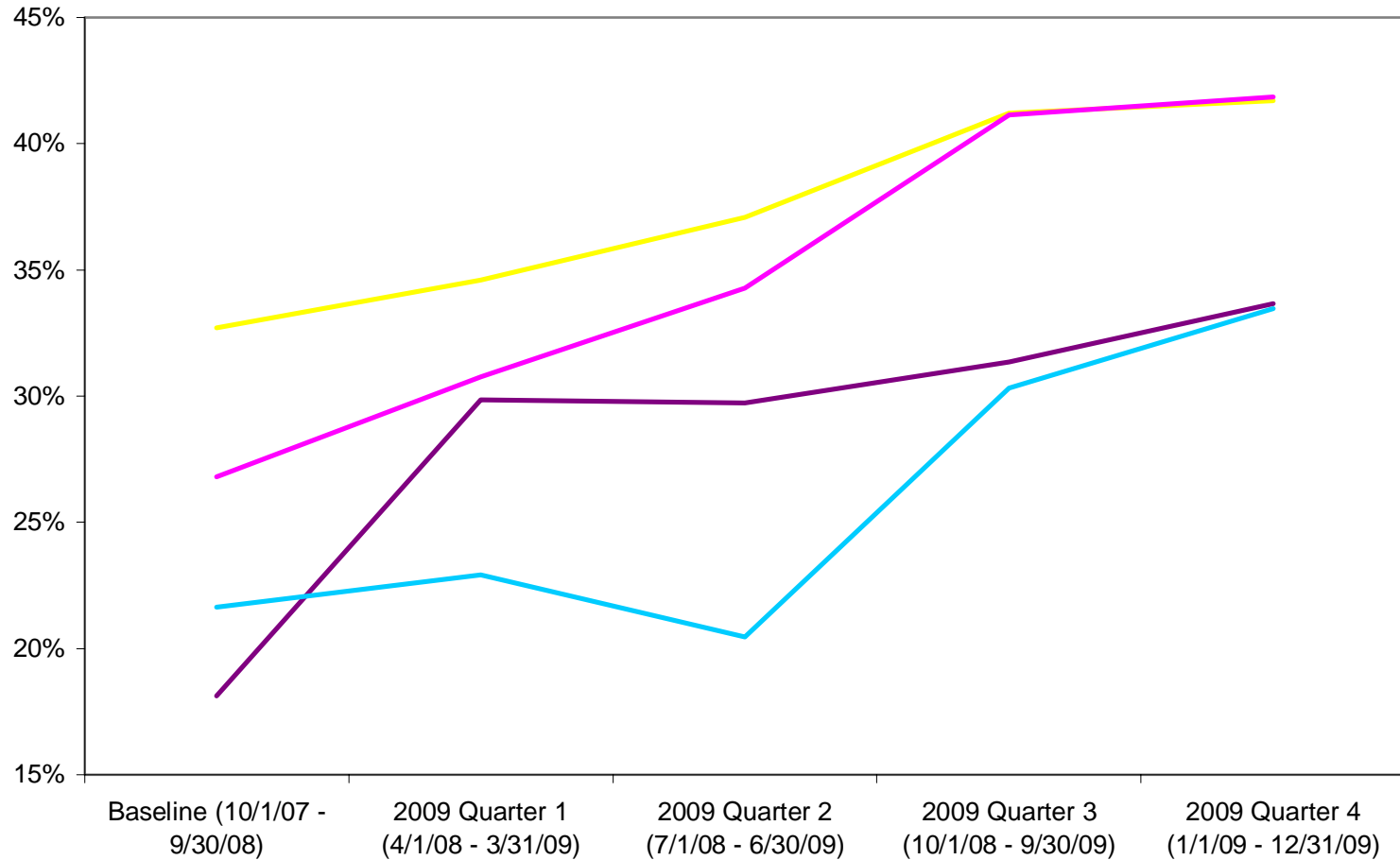
Results: Qualitative changes at Practice Sites

- Enhanced care coordination
- Enhanced patient engagement leading to better quality
- Use of Advanced HIT functionality to manage populations
- More pro-active care teams
- Happier providers

Rhode Island Chronic Care Sustainability Initiative

Diabetes Measures

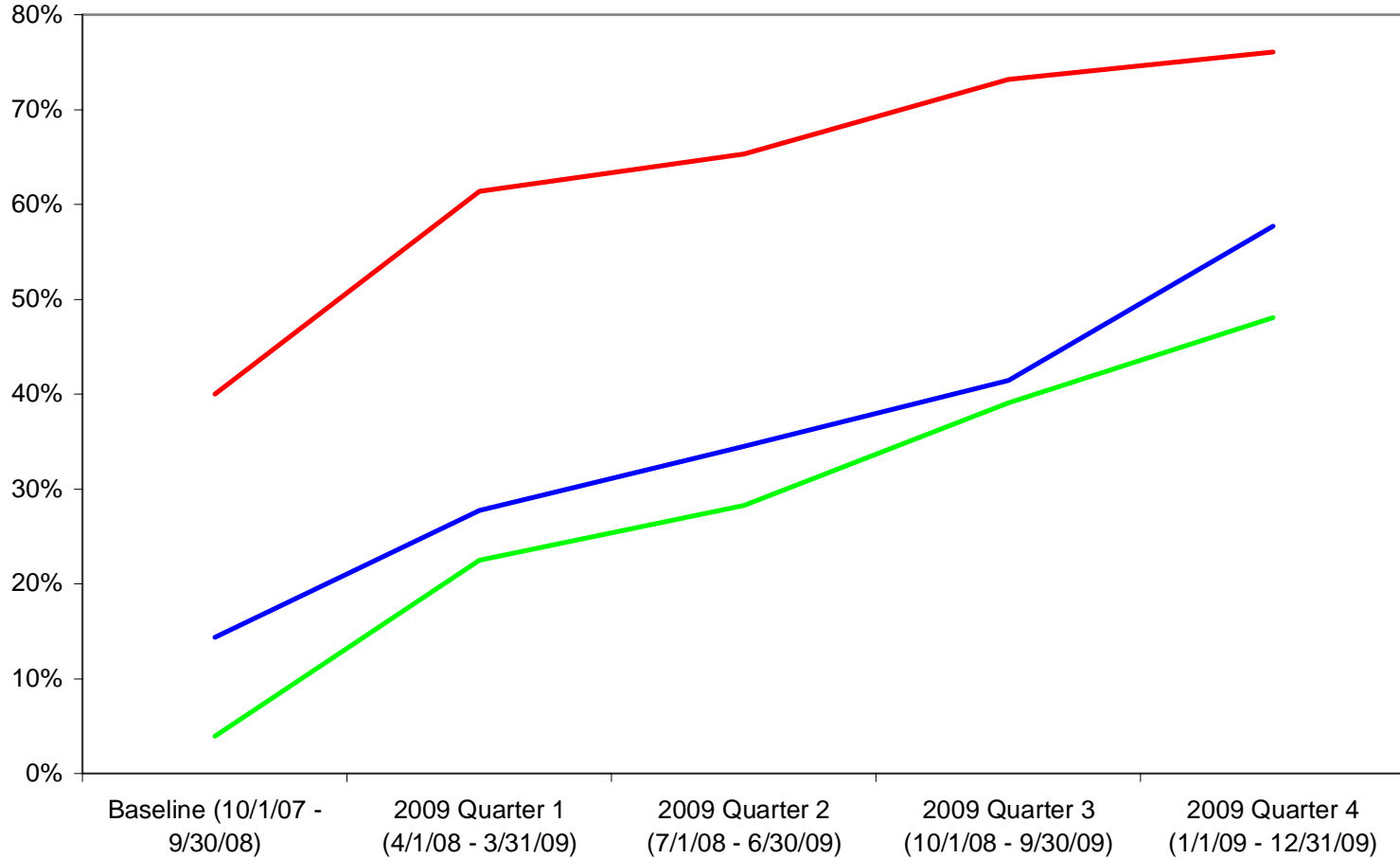
Baseline to Q4 2009



Rhode Island Chronic Care Sustainability Initiative

Non-Diabetes Measures

Baseline to Q4 2009



— Coronary artery disease patients prescribed a beta blocker
 — Patients (18+) with a documented depression screening
 — Current smokers who received advice to quit

Future

- Legislation being introduced to institutionalize collaborative and multi-payer involvement
- Decisions on how to formalize convening and management infrastructure
- More formal connections with hospitals and community resources
- Medicare?

Implications for Hospitals

- PCMH is designed to keep people out of hospitals as much as possible
 - ED use
 - ACS admissions
 - 30 day re-admissions
- New Payment systems needed to reward hospitals that work with Medical Homes to improve care

Contact:

Deidre S. Gifford, MD, MPH
CSI Rhode Island Project Director
Health Progress
401.541.9000
Deidre_Gifford@Brown.edu

