Show Me the Data: Do Patient–Centered Medical Homes Work?

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Transformation requires...
Defining the medical home

The medical home is an *approach* to primary care that is:

- Patient-Centered
  Supports patients in managing decisions and care plans.

- Committed to quality and safety
  Maximizes use of health IT, decision support and other tools.

- Coordinated
  Care is organized across the ‘medical neighborhood’

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

- Comprehensive
  Whole-person care provided by a team

Source: www.ahrq.gov
National Imperative: “Triple Aim”

Better Patient Experience

"Triple Aim"

Lower Per Capita Health Care Costs

Improved Quality (better outcomes)

Lower Per Capita Costs?

Manage high-risk, high need populations

- Risk stratification and diligent monitoring for all patients
- Right care, right place, right time
- Track care plans and medication adherence
- Care coordination across continuum of care
- Patient engagement and activation
Working with patients based on their needs

Outreach/screening: Low Risk, Low Cost

Care Management: Medium Cost, Manageable Risk

The “Boundary” is Flexible

Case Management: High Risk, High Cost

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Better Patient Experience of Care?
Improved Access to Care & Compassionate Care

- 24/7 access to care team (phone or e-consults with nurses, etc.)
- Open scheduling & alternatives to traditional face-to-face visits, including telemedicine, group visits, e-consults
- Culture of compassion and personal relationship with patient
- Communication, communication, communication!
Terminology preferred by patients and consumers

Meeting patients where they are: Authentic Patient Engagement

IOM (2002); modified from Dahlgren and Whitehead (1991)
Improved Population Health Outcomes?

*Care is coordinated and data shared electronically*

- Data shared across providers and institutions and information available at point of care
- Patients engaged through electronic records, portals, mobile apps, email
- Focus on whole person and recognition of behavioral health needs
Connecting the dots: Care coordinators/diverse care teams

- Care coordinators
- Patient navigators
- Health coaches
- Behavioral health/mental health
- Community supports and social workers
- Pharmacists
Technology needed but interoperability is required

“Top Ten List” of health IT-based population health management tools:

- Electronic Health Records (EHRs)
- Patient registries
- Health information exchange
- Risk stratification
- Automated outreach
- Referral tracking
- Patient portals
- Telehealth / telemedicine
- Remote patient monitoring
- Advanced population analytics
What’s the evidence that this model of care is effective?
The reports of our death are greatly exaggerated.
The Patient-Centered Medical Home’s Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013

January 2014
Description of Methods

- Examined medical home/PCMH studies published between August 2012 and December 2013
  - Peer-reviewed scholarly articles
  - Industry reports

- Explored relationship between “medical home/PCMH” model of care and Triple Aim outcomes
  - Predictor variable: “Medical home” or “PCMH”
  - Outcome variables: Cost & utilization; care experience (access & patient satisfaction); health outcomes (population health & preventive services)

- Resulted in 13 peer reviewed (academic) studies, and 7 industry reports
PCMH Peer Reviewed Outcomes

Cost & Utilization
- 61% of studies report cost reductions
- 61% report fewer ED visits
- 31% report fewer inpatient visits
- 13% report fewer readmissions

Care Experience
- 31% of studies report improved access
- 23% of studies report improved patient satisfaction

Health Outcomes
- 31% of studies report increase in preventive services
- 31% report improvements in population health
PCMH Industry Generated Outcomes

- 57% of studies report cost reductions
- 57% report fewer ED visits
- 57% report fewer inpatient visits
- 29% report fewer readmissions

Cost of Care Utilization

- 14% of studies report improved access
- 14% of studies report improved patient satisfaction

Care Experience

- 29% of studies report increase in preventive services
- 29% report improvements in population health

Health Outcomes
This map includes a diverse range of programs using patient-centered medical homes (PCMH) and enhanced primary care teams as the model for improving health care delivery. Click the map for a summary of all public and commercial PCMH programs in the State (State View). For more information on what programs are included visit our Frequently Asked Questions (FAQ) page.

* Darker colors indicate more PCMH-related activity
## Colorado

### State PCMH Activity

<table>
<thead>
<tr>
<th>CHIPRA</th>
<th>MAPCP</th>
<th>Dual Eligible</th>
<th>2703 SPA</th>
<th>CPC</th>
<th>SIM Award</th>
<th>PCMH QHP</th>
<th>PCMH Legislation</th>
<th>Private Payer</th>
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### Public Payer Programs

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<tr>
<th>Program Name</th>
<th>Payer Type</th>
<th>Coverage Area</th>
<th>Parent Program</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Colorado Medicaid Accountable Care Collaborative (ACC)</td>
<td>Medicaid</td>
<td>Statewide</td>
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### Multi-Payer Programs

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<tbody>
<tr>
<td>Colorado Comprehensive Primary Care Initiative</td>
<td>Multi-Payer</td>
<td>Statewide</td>
<td>CMS Comprehensive Primary Care Initiative</td>
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### Private Payer Programs

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<th>Coverage Area</th>
<th>Parent Program</th>
<th>Outcomes</th>
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### State Facts:

- **Population:** 5,076,000
- **Uninsured Population:** 15%
- **Total Medicaid Spending FY 2012:** $4.7 Billion
- **Overweight/Obese Adults:** 55.7%
- **Poor Mental Health among Adults:** 36.3%
- **2014 Medicaid Expansion:**
Program Location: Denver, CO
Number of Practices: 16
Payer Type: Multi-Payer
Partner Organizations: HealthTeamWorks
Payers: Anthem-Wellpoint United Healthcare Humana Aetna Cigna Colorado Medicaid CoverColorado

Description:
Completed in June 2012, this 3-year project was one of the first multi-payer medical home pilots. The project involved 5 private health plans and the State’s high-risk pool carrier, Cover Colorado, who provided additional compensation to 16 primary care practices. All participating practices were required to achieve at least level 1 PCMH recognition by the National Committee for Quality Assurance. HealthTeamWorks provided support to practices on quality improvement and transformation to PCMH through individual coaching and learning collaboratives. Preliminary evaluation results showed reduction in emergency department utilization and reduced hospital admissions. This project laid the foundation for a significant expansion of support to PCMH in Colorado including the Colorado Comprehensive Primary Care Initiative, Colorado Medicaid Accountable Care Collaborative, and the Colorado Medical Home Initiative.

Payment Model:
All of the participating plans agreed to provide a per member per month care management fee to participating practices for up to 20,000 plan members in addition to traditional fee-for-service and a pay-for-performance bonus.

Fewer ED / Hospital Visits:
- 15% fewer ED visits
- 18% fewer inpatient admissions
- Number of specialty visits remained flat (v. 10% increase in non-PCMH practices)

Improved Health:
- Improvements across all measures of diabetes care

Improved Patient/Physician Satisfaction:
- 95% of patients said care setting was well organized and efficient
- 97% said they would recommend it to family/friends
- 90% said it was easy to speak to a physician when they called
VISIT THE PCMH MAP AT
WWW.PCPCC.ORG/INITIATIVES
Payment Reforms: Necessary to sustain the model (and the progress made)
Primary Care Remains Undervalued

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

- Primary Care: 4%
- Drugs: 17%
- Professional procedures (non-hospital): 30%
- Hospital inpatient: 21%
- Hospital outpatient visits/other: 28%

Trajectory to Value-Based Purchasing
It is a journey, not a fixed model of care

- **HIT Infrastructure:** EHRs and Connectivity
- **Primary Care Capacity:** Patient Centered Medical Home
- **Operational Care Coordination:** Embedded RN Coordinator and Health Plan Care Coordination $
- **Value/Outcome Measurement:** Reporting of Quality, Utilization and Patient Satisfaction Measures
- **Value-Based Purchasing:** Reimbursement Tied to Performance on Value

Supportive Base for ACOs, PCMH Networks, Bundled Payments, Global Capitation

Source: THINC - Taconic Health Information Network and Community
ACO Growth Since 2011

A Commonwealth Fund study proposes replacing Medicare’s current formula for determining physician fees with a pay-for-value approach that would:

- Increase payments for providers in accountable care organizations, patient-centered medical homes, and other innovative models of care
- Strengthen primary care and care teams
- Promote bundled payments that combine fees for hospital services, physician services, and some follow-up care.

Over 10 years, these policies could save:

- Federal Government: $788 billion
- Households: $291 billion
- Private Employers: $91 billion
- State & Local Governments: $163 billion

$1.3 trillion in systemwide savings
PCMH at ♥ of “Medical Neighborhood”

- Community Centers
- Public Health
- Schools
- Employers
- Faith-Based Organizations
- Home Health
- Hospital
- Pharmacy
- Oral Health
- Mental Health
- Specialty & Subspecialty
- Skilled Nursing Facility
- Health IT

Patient-Centered Medical Home

Health IT

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Health IT
Role of the Collaborative

– **Challenge** the status quo and **drive** the marketplace
– Disseminate timely **information and evidence**
– Provide **networking & educational opportunities**
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