

APPENDIX B. The Year in Review: Case Study Snapshots

As the market continues to coalesce around the principles of the medical home model, the industry has taken an increasingly sophisticated approach to operationalizing this patient and family centered philosophy of care delivery. This year we saw many standout results from leading health plans, state initiatives, integrated health systems, and all of their partners from private practices, community health centers, state and federal agencies, and community organizations. Many organizations tested innovative strategies to advance and scale their PCMH initiatives, including the use of care managers, care coordinators, and patient navigators on care teams. These critical staff roles are well-recognized for ensuring that patients and their families are well-managed and informed throughout their care experience. Others leveraged health information technology to enhance patient-provider communications, after-hours access, and population health management.

Veterans Health Administration Patient Aligned Care Team (PACT)

National Program, 5 million patients

Publication Date: July 2013

The VA's Veterans Health Administration (VHA) operates one of the largest integrated health

RESULTS

- 8% fewer urgent care visits
- 4% fewer inpatient admissions
- Decrease in face-to-face visits
- Increase in phone encounters, personal health record use, and electronic messaging to providers

delivery systems in the United States, delivering comprehensive care to approximately five million Veterans. VA's PCMH Patient initiative includes a care team model that incorporates multidisciplinary clinical and support staff who deliver all primary care and coordinate the remainder of patients' needs, including specialty care. To optimize workflow and enhance continuity of care, staff are organized into "teamlets" that provide care to an assigned panel of about 1,200

patients. A teamlet consists of 1 primary care physician, 1 registered nurse care manager, 1 licensed practical nurse or medical assistant, and 1 administrative clerk. In addition, the program instructs facilities to enact advanced access scheduling, including same-day appointment slots. Facilities are also asked to conduct more appointments via phone and group appointments

BlueCross BlueShield of Michigan Physician Group Incentive Program

Michigan (statewide), 3 million patients

Publication Date: July 2013

Blue Cross Blue Shield of Michigan's PCMH program, one of the largest in the nation with nearly

RESULTS

- 13.5% fewer pediatric ED visits
- 10% fewer adult ED visits
- 17% fewer inpatient admissions
- 6% fewer hospital readmissions
- Savings of \$26.37 PMPM
- \$155 million in cost savings

2,500 practices, yielded significant improvements in quality and preventive care. In fact, the health plan estimates savings of \$155 million in the program's first three years. These avoided costs represent the savings achieved relatively early in the program's history and factor in costs at all practices in the program, not just those that had been designated as PCMH-based practices. The program demonstrated that cost savings achieved by highly developed PCMH practices are substantially greater. The analysis also shows that, when physicians fully

transform their practices to the PCMH model, it results in higher quality and improved preventive care.

UPMC Health Plan

Pennsylvania, 23,390 patients

Publication Date: July 2013

UPMC Health Plan is part of a large, integrated delivery and financing system headquartered in Pittsburgh, Pennsylvania. From 2008 through 2010, sites participating in the plan's PCMH pilot

RESULTS

- 2.8% fewer inpatient admissions
- 18.3% fewer hospital readmissions
- 2.6% reduction in total costs
- 160% ROI
- 6.6% increase in patients with controlled HbA1c
- 23.2% increase in eye exams
- 9.7% increase in LDL screenings

achieved lower medical and pharmacy costs; and lower utilization of services such as ED visits, hospital admissions and readmissions. The plan also experienced a 160 percent return on the plan's investment when compared with nonparticipating sites. As part of the initiative, UPMC provided each participating site with a practice-based nurse care manager, who was trained and employed by the health plan. Six care managers were assigned to the ten sites and were made available by telephone and electronically to their assigned practices, regardless of which office they were in at any particular time.

Practice-based care managers provided care

management support at the participating sites for certain high-need members with one or more chronic conditions, including diabetes, heart disease, depression, and asthma. Members were identified as high need based on a risk-stratification methodology that combined data from a variety of sources.

CareFirst Blue Cross Blue Shield

Maryland, 1 million patients

Publication Date: June 2013

CareFirst BlueCross BlueShield announced that the second-year of its PCMH program, one of the nation's earliest and largest, demonstrated \$98 million less in health care costs for its 1 million members. To support its PCMH program, the program facilitates implementation of care plans directed by primary care physicians with the support of local care coordination teams led by RN care coordinators. The care coordinators arrange for and track the care of those members who are

RESULTS

- \$98 million in total costs savings
- 4.7% lower costs for physicians that received an incentive award

at highest risk or who would benefit most from a comprehensive care plan. In addition, approximately 66 percent of participating primary care panels – groups of physicians that join together to participate in the PCMH program – earned increased reimbursements for their 2012 performance in the program

Oregon Health Authority Coordinated Care Organizations (CCOs)

Statewide Medicaid Program, 600,000 patients

Publication Date: November 2013

Oregon's local coordinated care organizations (CCOs) provide health care to more than 600,000

RESULTS

- 9% reduction in ED visits
- 14-29% fewer Ed visits for chronic disease patients
- 12% fewer hospital readmissions
- 18% reduction in ED visit spending
- Reduced per capitol health spending growth by >1%

Medicaid patients, and have demonstrated improvements in several key areas while controlling costs. The CCOs began serving Oregon Health Plan members in 2012, and include over 450 PCMH practices and clinics. The Oregon Health Authority's November 2013 "Health System Transformation Progress Report" also identified reductions in ED visits and hospitalizations, while primary care visits have increased 18 percent. The report also demonstrated increases in electronic health record adoption among measured providers; in 2011, 28

percent of eligible providers had EHRs, and by June of 2013, 57 percent of them had adopted EHRs.