

Patient Centered Medical Home (PCMH) The Wisconsin Perspective

Alliance Learning Circle
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Background: What is a PCMH?

A Patient Centered Medical Home (PCMH) is a more effective and efficient model of health care delivery that produces:

- Better health outcomes
- Lower costs
- Greater equity in health



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Background: What is a PCMH?

Joint principles from AAFP, AAP, ACP and AOA outline the model, attributes, and payment structure

Background: What is a PCMH?

In a Patient Centered Medical Home:

- Patients have a **relationship** with a personal physician.
- A practice-based care team takes collective responsibility for the patient's **ongoing care**.
- The **care team** is responsible for providing or arranging **all** the patient's health care needs.

Background: What is a PCMH?

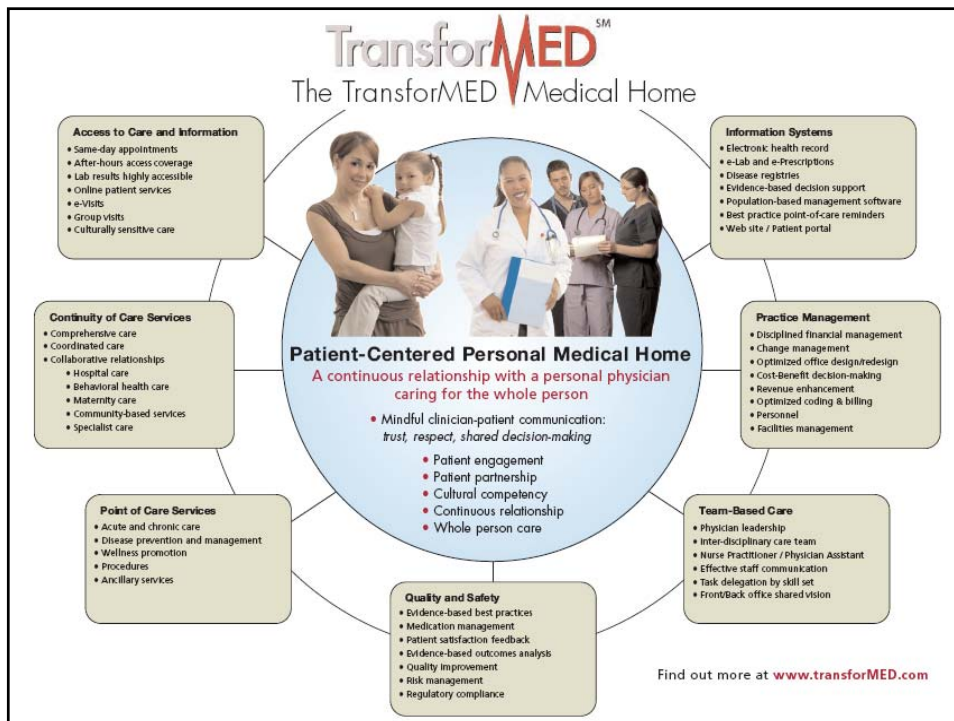
In a Patient Centered Medical Home:

- Patients can expect care that is **coordinated** across care settings and disciplines.
- **Quality** is measured and improved as part of daily work flow.
- Patients experience **enhanced access** and communication.
- The practice uses **electronic health records**, registries & other **clinical support systems**.



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Why PCMH?

A Patient Centered Medical Home delivers:

- **Improved patient care** and satisfaction
 - In the US, studies show patients with a primary care physician had **33% lower costs of care** and were **19% less likely to die** – than patients who worked solely with specialists.
 - Recent studies estimate that if every American had access to a Medical Home, national health care expenditures would **drop by 5.6%** – translating into a national savings of at least \$67 billion per year.

Why PCMH?

A Patient Centered Medical Home delivers:

- **Enhanced payment** in a fee-for-service and pay-for-performance environment
- Better organized and **more efficient** office processes
- Higher physician and staff **satisfaction**

How is a Practice Recognized as a PCMH?

NCQA has developed a scored criteria set of standards (PPC-PCMH™) for medical practices to demonstrate that they are functioning as PCMHs

- Includes a tiered recognition system based upon score (see www.ncqa.org)

TransforMED has a MHIQ tool to assess a practice's Readiness

AAFP has "Road to Recognition"



PCMH in Wisconsin

An increasing number of WI practices are in the process of obtaining NCQA recognition as a Patient Centered Medical Home.

The Wisconsin Academy of Family Physicians (WAFP) is making the advancement of PCMH its **#1 priority**.



PCMH in Wisconsin

The WAFP Goals, over the next 3-5 years, are:

- To help our members understand, embrace and implement PCMH
- To educate payers and legislators about the benefits of the medical home concept and achieve payment reform
- To reform the health care payment system to recognize PCMH

We believe the Patient Centered Medical Home is **our best hope for meaningful health care reform** as evidenced by other successful implementations.

Payment Structure Reform

Fee for service for face-to-face visits

Care management fee to recognize added value

Additional payment for achieving measurable and continuous quality improvement

Payment Structure Reform

Payment reform must recognize the added value provided to patients with Patient Centered Medical Home

PCMH in Practice

North Carolina: 2003 – 2006

Patient Centered Medical Home implementation saves the state of North Carolina **more than \$200 Million** each year in health care costs.

PCMH in Practice

Community Care of North Carolina

- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.

PCMH in Practice

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- Additional investment in primary care of \$16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients (the total net cost trend was a savings of \$17 per patient per year, which was not statistically significant). Unpublished data from the 24 month evaluation reportedly show a statistically significant decrease in total costs.

PCMH in Practice

HealthPartners Medical Group BestCare PCMH Model

- 39% decrease in emergency room visits, 24% decrease in hospital admissions
- Overall costs in the PCMH clinics decreased from being 100% of the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average

PCMH in Practice

Geisenger Health System ProvenHealth Navigator PCMH Model

- Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months.
- Estimated \$3.7 million net savings, for a return on investment of greater than 2 to 1.

PCMH in Practice

Genesee Health Plan HealthWorks PCMH Model

- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

PCMH in Practice

Colorado Medicaid and SCHIP

- Median annual costs \$785 for PCMH children compared with \$1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).

PCMH in Practice

Intermountain Healthcare Medical Group Care Management Plus PCMH Model

- 10% relative reduction in total hospitalizations, with even greater reductions among the subset of patients with complex chronic illnesses. Net reduction in total costs \$640 per patient per year (\$1,650 savings per year among highest risk patients).



PCMH in Practice

Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days
- Annual net Medicare savings of \$1364 per patient and \$75,000 per Guided Care nurse deployed in a practice



WAFP Efforts

What WAFP is doing *for Members*:

- We've compiled **tools** you can use to better understand PCMH and its benefits to your patients and your practice.
- We are conducting monthly **phone/web conferences**, open to all members, staff and colleagues. Each conference will feature a PCMH topic and will be followed by Q&A.

WAFP Efforts

What WAFP is doing *on the Policy front*:

- Our lobbyist is actively talking with Wisconsin state legislators about the benefits of PCMH.
- In November, 2008, we testified before the Wisconsin Legislative Council in favor of a PCMH pilot program in the state.
- We developed a proposed PCMH Medicaid Payment Program.
- Championed a Medicaid Pilot program in the last budget

WAFP Efforts

What WAFP is doing *on the Policy front*:

WAFP has proposed a blended payment plan for Medical Assistance incorporating:

- Enhanced fee for service fees
- A care management fee
- Pay for Performance (P4P) bonuses

WAFP Efforts

Multi Stakeholder Demonstration Project

WAFP is collaborating with MetaStar and others:

- Expected outcomes
- Role of the convener
- Demonstration guidelines
- Timeline
- What to measure
- Participants

Barriers to PCMH

- The business plan – what is the ROI? How do I know there is going to be more \$ to pay for the infrastructure cost.
- EHR – cost and time to implement especially for the small practices
- Clinic administration and/or system support – or lack there of
- Cost, cost cost – again especially for small practices

Barriers to PCMH

- Time – already too busy
- Team approach vs current operations - hard to change
- I am already doing most of this stuff!
- Change management is hard
- Will the dollars be there?
- A significant part of the practice needs to be affected by PCMH to warrant the change.

Barriers to PCMH

- NCQA recognition is costly – staff time and fees without payment changes guaranteed.
- WI is already efficient and we cannot realize the savings other pilots have achieved
- What and how do we measure – cost, outcomes, satisfaction
- Not enough practices are NCQA recognized

For More Information

Visit: www.wafp.org/pcmh

Call: Wisconsin Academy of Family Physicians

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Questions?



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Thank You



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