

EXECUTIVE SUMMARY

PURSuing THE PATIENT-CENTERED MEDICAL HOME

APRIL 7, 2010

National, local and virtual approaches to creating the Patient-Centered Medical Home (PCMH) were explored by multiple speakers at an Alliance Learning Circle event on April 7, 2010.

A National Shift

Dr. Paul Grundy noted that the federal government has established that PCMH is the future standard for medical care by assigning a PCMH and primary care manager to every patient served by the Department of Defense and Veterans Administration. That position is reinforced by National Institute of Health grant policies and pilot programs established by the U.S. Department of Health and Human Services under the Medicare-Medicaid PCMH Advanced Primary Care Demonstration Initiative.

"It's the future of our health care delivery system," Grundy said. Grundy is the director of healthcare, technology and strategic initiatives for IBM Global Wellbeing Services and Health Benefits and chairman of the Patient-Centered Primary Care Collaborative that provides national leadership for the PCMH movement.

As an employer operating around the world, IBM is using PCMH to create the standard for how it buys health care, how employees pay for care, and even where it will locate manufacturing plants. That is backed by the design of its health benefit plan, which eliminates the co-pay for primary care services to encourage patients to establish and rely on a medical home to coordinate their health care.

"We no longer are willing to pay for uncoordinated, episodic care," Grundy said. "It should be considered unethical to deliver that care."

IBM is participating in six pilot projects in New York and Vermont aimed at testing PCMH as a way to deliver coordinated, integrated, accessible care. Key elements of the PCMH strategy include an emphasis on communicating with patients to engage them in their care, including the use of e-mail; open access to care, including the ability to reach the doctor after hours; and establishing a strong relationship between the patient and the physician-based team of caregivers.

"We have made it clear to providers that this is the journey we're on and we expect them to be on that journey with us," Grundy said.

Deciding What to Buy

Both consumer surveys and patient data show that PCMH makes a difference in the level of care that consumers receive. Care provided by a primary care "comprehensivist" typically costs one-third less than care provided by a specialty "partialist" due to the relationship that evolves over time.

What is it?

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.
- » 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 and other clinical support systems.

Source: Wisconsin Academy of Family Physicians

This relationship is deeply desired by consumers, who also cite access and convenience as key elements in surveys. Grundy advises employers to seek this level of relationship for the health care they buy on employees' behalf.

"I want to buy a relationship with a healer that amplifies in cadence the message of health and wellness that I'm engaged in as an employer," Grundy said.

In comparison, the established method of buying care on an episodic basis from specialists often doubles costs, Grundy said. For example, IBM learned the incidence of heart surgery could be halved in local communities based on the type of care provided by local health systems.

Similarly, the cost of employees' last six months of life varies from an average of \$177,000 to \$17,000 depending on where employees live.

Early results from PCMH pilots bear out projections for PCMH cost savings, with a 16 percent decrease in the cost of ambulatory care in one Pennsylvania project. In North Carolina, another pilot led to a 71 percent shift from in-hospital care to out-of-hospital care.

The disparities are even clearer when IBM compares the experiences of its U.S. workforce with workers in other countries. For example, IBM employees in New Zealand are 57 times less likely to be hospitalized for diabetes than in the United States.

Enlisting Support

More than 700 national organizations have endorsed the PCMH concept, including leading physician and nursing associations as well as business groups. These groups see PCMH's potential to deliver smarter health care by gaining access to consistent, centralized data that can be applied to drive decisions and track patient care.

Once physician practices implement the PCMH model, both physician and nurse satisfaction increases rapidly because PCMH is the type of practice envisioned by many caregivers when they decided to pursue a career in health care.

Meanwhile, hospitals and physician practices are recognizing that they can market the superior experience delivered by PCMH directly to patients. Using a PCMH approach to create a 4 percent shift in primary care physician referrals to specialists is typically sufficient to persuade other physicians and health providers to adopt the approach.

But a significant dilemma remains for providers, who may be unable to obtain adequate payment for comprehensive care under current payment models. Both employers and payers may resist paying more for comprehensive care until PCMH proves its worth. Solutions are likely to emerge through pilot projects operated at the state level.

Implementing PCMH Reduces Costs

Group Health Cooperative of Puget Sound:

- » 29% reduction in ER visits
- » 11% reduction in ambulatory sensitive care admissions
- » Additional investment in primary care of \$16 per patient per year associated with offsetting cost reductions, with net result of no increase in total cost

Genesee Health Plan HealthWorks PCMH Model:

- » 50% decrease in ER visits
- » 15% fewer inpatient hospitalizations
- » Total hospital days per 1,000 enrollees are now 26.6% lower than competitors

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 \$1,364 per patient and \$75,000 per Guided Care nurse deployed in a practice

An international example

The PCMH concept helped the country of Denmark shift from **155 hospitals** to **25 hospitals** nationwide.

Source: Dr. Paul Grundy

A Wisconsin Campaign

The Wisconsin Academy of Family Physicians (WAFP) has made pursuing the PCMH approach to primary care its top priority, according to Executive Director Larry Pheifer.

PCMH represents a “radically different” way of delivering care for physicians and their staffs. Pheifer noted that three-fifths of the physician’s day is unscheduled to allow the physician to deal with patient’s needs as they arise.

The significant advantages provided to patients and physicians make it worthwhile to adapt practices to implement the PCMH concept. In addition to improved satisfaction, Pheifer said recent studies estimate that if every American had access to a medical home, national health expenditures would drop 5.6 percent to save \$67 billion per year nationwide.

Physician practices can pursue the PCMH concept by following the American Academy of Family Physicians “Road to Recognition” program, which helps them achieve the three levels of PCMH certification offered by the National Committee for Quality Assurance (NCQA). Six Wisconsin practices are currently recognized as offering PCMH at the highest level certified by the NCQA, with approximately another 50 practices currently pursuing it.

Seeking Savings

Wisconsin’s leadership role in linking consumers to care is often seen as a benefit, but it has proved to be a disadvantage in implementing PCMH because payers are skeptical about the amount of additional savings that it is possible to achieve. That makes it difficult to adjust payment models to cover the costs of PCMH.

“There has to be a different way to pay for it,” Pheifer said. PCMH requires a blended payment system based on three elements:

1. A fee for service to cover the care that is delivered to individuals;
2. A care management fee on a per member, per month basis; and
3. A pay for performance plan to reward quality.

Pheifer hopes that the multi-stakeholder demonstration project group currently exploring options in Wisconsin will help prove the case for PCMH. He urged businesses to participate in the project to achieve the gains of PCMH for state residents.

“At some point, there’s got to be a leap of faith,” Pheifer said.

A Virtual Medical Home

Employers can achieve many of the benefits of the PCMH concept in a “virtual” way by using the Coordinated Health/Care Program™ provided by Quantum Health through a partnership with The Alliance.

Randall Gebhardt, president and chief operating officer, said Quantum embeds the Coordinated Health/Care Program within existing self-funded health plans, branding it with the employer’s name.

Benefits of PCPs

Patients with a primary care physician:

- » Have 33% lower costs of care
- » Are 19% less likely to die

Source: Wisconsin Academy of Family Physicians, based on U.S. studies

Why Employers Care About PCMH

- » Improved coordination of health care
- » Enhanced quality of care
- » Better clinical outcomes
- » Improved patient satisfaction
- » Hopefully, lower health and lost productivity costs

Source: Dr. Paul Grundy

Pursuing Payment Reform

The Alliance is participating in the Wisconsin Payment Reform Initiative (WPRI) to help drive fundamental change in the payment model, which includes examining pilots that will implement the PCMH concept and examine the way providers are paid based on patient outcomes.

The Coordinated Health/Care Program gives employers, employees and their family members a single point of contact for benefits, eligibility and claims. This gives Quantum the opportunity to intervene with employees to help them get appropriate care, eliminate duplicated tests and procedures, and save an average of \$1,092 per employee in 2008.

“We intercept 61 percent of health plan members in a typical year,” Gebhardt said. “That is critical to making things happen.”

Most opportunities to change health cost trends occur in managing utilization, Gebhardt said. That happens in two ways. First, Quantum’s Care Coordinators help make health utilization more efficient. Second, they help employees become healthier over time, which reduces the need for health care to achieve savings in a three to five-year period.

Reducing Confusion

Care coordinators play a vital role by helping patients cope with the fragmentation of the health system that causes frustration, confusion and unnecessary duplication of services. Patients typically welcome the opportunity to clarify information and get a better grasp of health needs, Gebhardt said.

Creating a single point of contact for patients allows Quantum to collect all its data on a single system, which provides additional opportunities to coordinate care. That approach is strengthened when employers design their health plan to provide incentives for using primary care.

While seizing opportunities to coordinate care makes it possible for Quantum to help employees and their companies now, Gebhardt stressed that the PCMH remains the model that patients want and need to change how they use health care.

“We hope that in five to eight years, every physician office has these tools.”

The Impact of Fragmentation

- » 44% of patients get “lost” in course of care and do not know who to contact.
- » 105 days is the average time required from the point of diagnosis to contact from a disease management nurse.
- » Satisfaction with traditional health plans is in the 45 to 65 percent range.

Source: Quantum Health