The Patient Centered Medical Home

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Thank You!!

Something We Can All Agree On!!

We Can Create a Better HealthCare System

-- less costly

-- better patient outcomes

-- higher satisfaction

WE MUST FOCUS ON PRIMARY CARE

- Better access for acute medical problems
- Better chronic disease management
- Better preventive care
- Better end-of-life care

Better Outcomes at a Lower Cost with Greater Satisfaction

LAKEVIEW, OREGON

BOMENGEN

TransforMED℠

The TransforMED Patient-Centered Model

A Medical Home for All

Access to Care and Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services
- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
  - Patient engagement
  - Provider/patient partnership
  - Culturally sensitive care
  - Continuous relationship
  - Whole person care

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Care Coordination
- Community-based resources
- Collaborative relationships
  - Emergency Room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care Transition

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at www.TransforMED.com

version 2.3.3 - 10/2009

Components of PCMH

- Patients who receive care from a PCMH have **continuous access to a personal physician** who provides comprehensive and coordinated care for the large majority of their healthcare needs.
- The PCMH would be **responsible for all of the patients' healthcare needs** – acute care, chronic care, preventive services, and end of life care working with teams of healthcare professionals.
- The PCMH would **coordinate the care** of its patients with specialists, lab/x-ray facilities, hospitals, home care agencies, and all other healthcare professionals on the patient care team.

Patient Centeredness….

- allowing patients free **choice** of physician
- providing **prompt appointments**, reducing waiting times
- delivering care based on the **best evidence** on clinical effectiveness
- empowering patients to partner with their personal physicians on **decision-making**
- providing care in a culturally and linguistically appropriate manner.

Health Information Technology

- Evidence based **decision support**
- **Patient registries** with recall systems to assist with chronic disease management
- Electronic medical record, electronic prescribing, electronic orders, electronic visits, patient portals, etc.

So, Does it Work?

WellMed

- Medical Management Company in San Antonio, Tx
- 26 clinics
- 100+ providers
- > 77,000 pts

- Primary care focus:
  - Fp's, general IM
  - Compensation 30-50% greater than the average
  - < 15 pts daily

WellMed Outcomes

- Admits/1000 < 200
- Bed days/1000 < 800
- Readmissions in 30 days 8-12%
- HgA1c, LDL near best in class

- Higher patient and provider satisfaction

WellMed ACO

HOSPITAL		48.0%
CARDIOLOGY		4.0%
DME		3.9%
RADIOLOGY		3.4%
FAMILY PRACTICE		3.3%
OPHTHALMOLOGY		2.8%
INTERNAL MEDICINE		2.6%
HOME HEALTH		2.3%
PATHOLOGY		2.1%
SURGERY CENTER		2.0%
SKILLED NURSING		2.0%
OOA HOSPITAL		1.5%
HEMATOLOGY		1.2%
ORTHOPAEDICS		1.2%
DIALYSIS		1.1%
AMBULANCE		1.0%
UROLOGY		1.0%

Five Years Later….

5000 Patients 60K Member Months	PMPM Cost Before	PMPM Cost After	Savings
Hospital	$691	$353	$20 Million
Cardiology	$25	$22	$180,000
Ortho	$9	$6	$180,000
Primary Care	$40	$55	<$900,000>

According to the Center for Evaluative Clinical Sciences at Dartmouth:

States that relied more on primary care have:

- **Lower Medicare spending** (inpatient reimbursements and Part B payments)
- **Lower resource inputs** (hospital beds, ICU beds, total physician labor, primary care labor and medical specialist labor)
- **Lower utilization rates** (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians); and
- **Better quality of care** (fewer ICU deaths and a higher composite quality score).

A Comprehensive Review Conducted by John's Hopkins University Revealed:

- adults with a primary care physician rather than a specialist had **33 percent lower costs of care** and were **19 percent less likely to die**
- each additional primary care physician per 10,000 persons is associated with a decrease in mortality rate of 3 to 10 percent

Patient-Centered Primary Care Collaborative Study:

- cross section of 10 PCMH projects in nearly every part of the country.
- Although the projects cover different population groups and vary in size, scope and age, they all achieved similar results.
- In every instance, the PCMH projects created **better coordination and more effective upstream care**, which led to **fewer hospitalizations and emergency room visits and a corresponding reduction in costs**.

- The North Carolina Medicaid program enrolls recipients in a network of physician-directed medical homes.
- A Mercer analysis showed that an **upfront $10.2 million investment** for North Carolina Community Care operations in SFY04 **saved $244 million** in overall healthcare costs for the state.
- Similar results were found in 2005 and 2006.[6]

THE BOTTOM LINE

Care delivered by primary care physicians in a PCMH is consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and lower Medicare spending.

For More Information:

- The Patient-Centered Primary Care Collaborative paper on Outcome of Implementing PCMH: http://pcpcc.net/files/Grumbach_et-al_Evidence-of-Quality_%20101609_0.pdf
- NCQA's practice standards for PCMH: http://www.ncqa.org/tabid/631/Default.aspx
- Report of the Deloitte Center for Health Solutions on PCMH: http://www.deloitte.com/view/en_US/us/Industries/US-federal-government/center-for-health-solutions/research/f25a02f31251b210VgnVCM2000001b56f00aRCRD.htm
- The AAFP's Joint Principles for ACO's and Joint Principles of the PCMH: http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20101118acojointprinciples.html
- TransforMED homepage: http://www.transformed.com/

Collect your thoughts and hold your questions for panel review.

Thanks

An Evolution in Medical Care

The medical home represents an evolutionary step in our health care system – it offers competitive advantage against the current practice model.

PCMH

The Group Health Experience

Jeremia Bernhardt, MD
Family Physician
Group Health Northgate

The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers

- Health Affairs, 29, no. 5 (2010) 835-843

Objectives

- Outline the major successes of Group Health's PCMH pilot

- Discuss lessons learned
- PCMH at GH in 2011

I’ll start with the fireworks

- The return on our investment was 1.5:1
- Estimated savings of $10.30 per member per month
- Quality was better
- Staff burnout was significantly less
- Patient experience was better

GH PCMH Pilot

- Prototype Clinic Characteristics
  - Downsized patient panels from 2300 per physician to 1800
  - Visit times increased to 30 minutes per visit
  - Enhanced staffing model
    - For every 10,000 patients
      - 5.6 physicians
      - 5.6 medical assistants
      - 2.0 LPN's
      - 1.5 PA's or ARNP's
      - 1.2 RN's
      - 1.0 clinical pharmacist

Results

- Compared differences in:
  - Patient experience
  - Provider burnout
  - Quality of care
  - Financial impact

Patient Experience

- Medical home patients reported better care experiences in the following areas:
  - Coordination of care
  - Access to care
  - Goal setting
  - Quality of doctor-patient interactions
  - Patient activation and involvement

Staff Burnout

- Medical home staff scored better in:
  - Emotional exhaustion
    - "I feel emotionally used up at the end of the workday."
  - Depersonalization
    - “I have become more callous toward people since I took this job.”
    - "I worry that this job is hardening me emotionally.”
  - Personal accomplishment
    - “I feel exhilarated after working closely with my patients.”
    - "I deal very effectively with the problems of my patients."

Clinical Quality

- The medical home clinic showed greater improvements in all composites of HEDIS measures.

Care Utilization at the Medical Home

- 6% fewer primary care visits
  - 80% more email communications
  - 5% more telephone visits
- More specialty visits
  - Initial surge but smaller difference with time
- 29% fewer ER visits
- 6% fewer inpatient admissions

Cost

- Primary care $1.60 more per member per month
- Specialty care $5.80 more per member per month

- ER savings of $4 per member per month
- Hospital savings of $14.18 per member per month

Savings

- Total net savings of $10.30 per member per month
- Return on investment of 1.5:1
  - Already had infrastructure investments including EHR
  - New investment on recruiting and hiring additional personnel

An Evolution in Medical Care

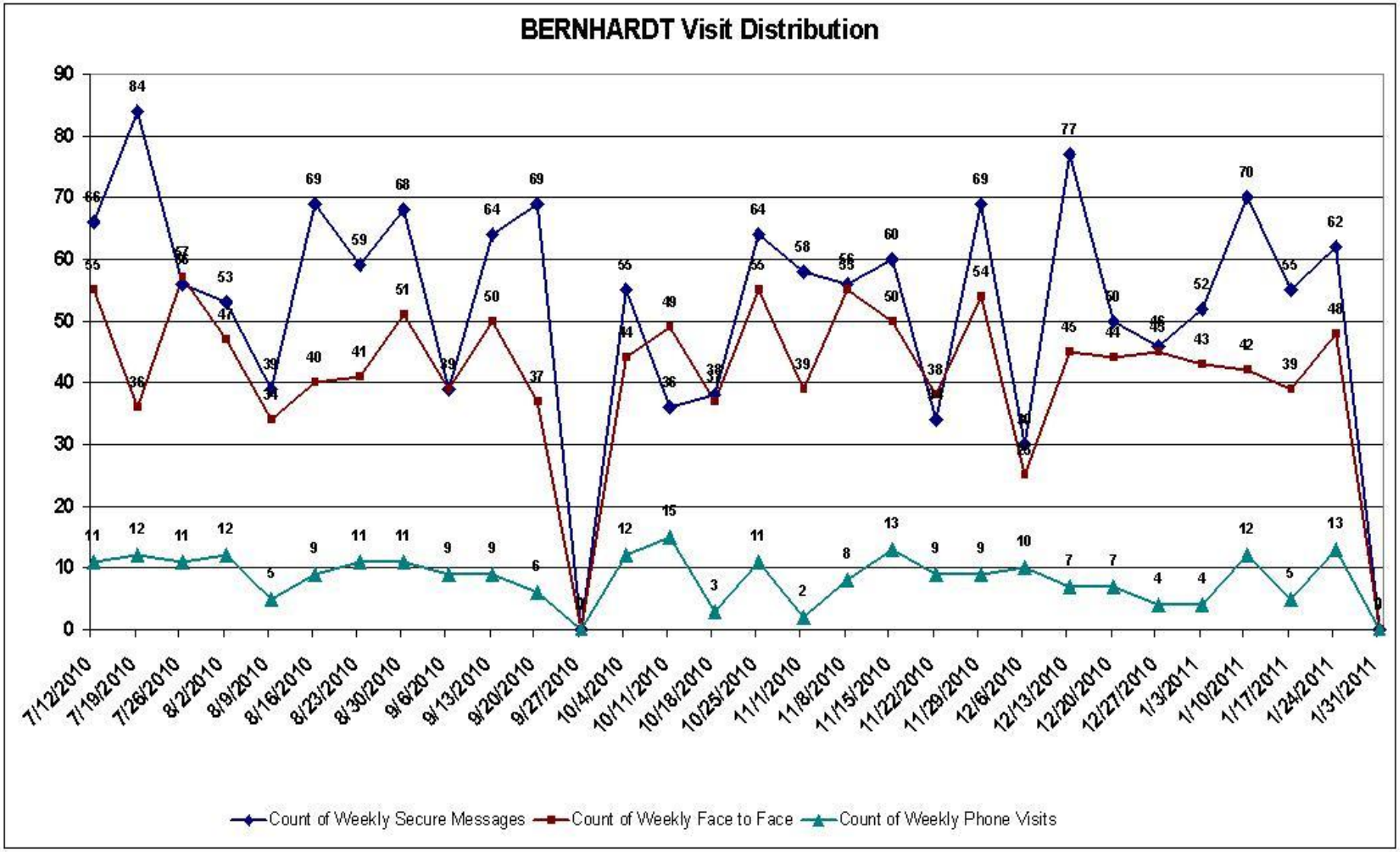
Group Health's PCMH project has shown that the PCMH offers specific competitive advantage in 4 areas: patient experience, provider experience, healthcare quality and utilization/cost.

Lessons Learned

- Invest in primary care
- Strong adaptive leadership
- Change management
- Patient centered EMR
- Each clinic has its own unique needs requiring unique solutions

GH's PCMH Core Principles

- Virtual medicine
- Chronic care management
- Visit preparation
- Patient outreach
- Call management
- Care team huddles
- Standard management practices


BERNHARDT Visit Distribution
90
80
70
60
50
40
30
20
10
0
7/12/2010
7/19/2010
7/26/2010
8/2/2010
8/9/2010
8/16/2010
8/23/2010
8/30/2010
9/6/2010
9/13/2010
9/20/2010
9/27/2010
10/4/2010
10/11/2010
10/18/2010
10/25/2010
11/1/2010
11/8/2010
11/15/2010
11/22/2010
11/29/2010
12/6/2010
12/13/2010
12/20/2010
12/27/2010
1/3/2011
1/10/2011
1/17/2011
1/24/2011
1/31/2011
Count of Weekly Secure Messages
Count of Weekly Face to Face
Count of Weekly Phone Visits

The framework for my thoughts

- Rural practice
- Physicians were integrated and intimate with organizational goals
- I had a good and trusting relationship with the physicians
- We had a common focus- the patient
- We were a Critical Access Hospital
- We were a designated Rural Health Clinic

Elements of the Successful Medical Home

An Administrator's Perspective

Key element #1: Patient Acceptance

- Patients need to understand and accept the role of the family practitioner
- They should be encouraged to stop self referrals to specialists and other providers
- They must see the family doctor as their advocate and coordinator of care

Key element #2: Organizational support

- You must embrace change
- You must reward change, even if it falters at the beginning

Key element #3: Commitment to family practice

- Many other providers now seem to want to be included as a “primary care” provider – peds, OB-GYN, internists, alternative medicine, chiropractors, naturopaths, etc.
- I’m talking about family practitioners only
- Encourage family practitioners to integrate the full scope of their training into their practice
- Appropriately compensate FPs
- Physician satisfaction is critical

Key element #4: Understand the FP-Specialist relationship

- You must insist that the specialist keeps the FP actively in the loop of medical care decisions

- Referrals from one specialist to another specialist must be with the approval of the FP

Key element #5: Effective Communication systems

- Electronic medical record

  -the major benefits:

  improved quality

  improved accuracy for coding

  legal protections

  pay for performance

  ? productivity

- the major problems
    - costs
    - frustration
    - MD acceptance
    - nursing acceptance
    - old data handling
    - outside documents
    - implementation schedule

Key element #6: Realistic financial expectations

- Charges: who gets paid for what?
- Capital investment
- Operations – expense and time
- System savings – the right person doing the right things
- Revenue
- Will the medical home ever break even?

Key element #7: Improving quality

- Documentation
- Communication
- Medical errors
- Prescriptions
- Audits
- Consistency

Key element #8: Pitfalls

- Making the computer central to the visit, rather than the patient
- Failure to maximize the medical home and EMR benefits
- “cookbook” medicine
- Wrong pace of implementation
- Fear of changing course if things aren’t working

- Failure to spend your money on the important things first
- Criticizing or penalizing physicians when productivity drops
- Failure to recognize that communication is not reimbursed, but you will be punished if you don’t do it
- Watching the money so closely that you miss the big picture and have a heart attack

Other consderations

- Government’s role
- Insurance companies’ role

Thank you!

- Doug Williams

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