Patient Centered Medical Home – The Future

@Paul_PCPCC
"A health system where primary care is the backbone and family doctors are the bedrock delivers the best health outcomes, at the lowest cost, and with the greatest user satisfaction."

Dr. Margaret Chan, Director General WHO
Primary Care Payment Reform Targeted in Multi-Payer Initiative

This is the first time CMS has targeted primary care payment reform on such a large scale.

| Table. Comparison of the Design Features of CPC and CPC+ Tracks 1 and 2 |
|---|---|---|
| **CPC** | **CPC+ Track 1** | **CPC+ Track 2** |
| **Size** | 7 Regions; ~500 practices | ≤20 Regions; ≤2500 practices | ≤20 Regions; ≤2500 practices |
| **Duration** | 4 y (2012-2016) | 5 y (2017-2021) | 5 y (2017-2021) |
| **Medicare care management fee**<sup>a</sup> | $20 PBPM PY1-2; $15 PBPM PY3-4; average across 4 risk tiers | $15 PBPM average across 4 risk tiers | $27 PBPM average across 5 risk tiers; $100 for highest-risk tier |
| **Medicare payment for office visits** | 100% FFS | 100% FFS | 100% FFS for non-evaluation and management; reduced FFS + up-front payment for evaluation and management |
| **Medicare incentive payment** | Shared savings based on quality metrics and TCOC<sup>b</sup> | $2.50 PBPM based on quality and utilization metrics | $4 PBPM based on quality and utilization metrics |
| **HIT partners** | Not required | Not required | Required |

**Abbreviations:** CPC, Comprehensive Primary Care; CPC+, Comprehensive Primary Care Plus; FFS, fee for service; HIT, health information technology; PBPM, per beneficiary per month; TCOC, total cost of care.

<sup>a</sup> Paid only for Medicare FFS beneficiaries attributed to participating practices

<sup>b</sup> Savings calculated based on any reduction in Medicare Part A and B expenditures.
Away from Episode of Care to Management of Population with Data

The System Integrator
• Creates a partnership across the medical neighborhood
• Drives PCMH primary care redesign
• Offers a utility for population health and financial management
Care by Design™ at University of Utah: Developing and Implementing Care Management, Engaging Patients, and Assessing Cost of Care

Michael K Magill, MD
Professor and Chairman
Department of Family and Preventive Medicine
University of Utah
School of Medicine and Community Clinics
Key principles

- **Personal healer** – each patient has an ongoing personal relationship with a physician for continuous, comprehensive care
- **Whole person orientation** – physician is responsible for providing all the patient’s health care needs or arranging care with other qualified professionals
- **Care is coordinated and integrated** – across all elements of the complex healthcare community
- **Quality and safety are hallmarks of the medical home** – Evidence-based medicine and clinical decision-support tools guide decision-making
- **Enhanced access to care is available** – systems such as open scheduling, expanded hours, and new communication paths between patients, their physician and practice staff
- **Payment is appropriate** – added value provided to patients who have a patient-centered medical home

36.3%  Drop in hospital days
32.2%  Drop in ER use
12.8%  Increase in chronic medication
-15.6% Total cost
10.5%  Drop in inpatient specialty care costs
18.9%  Ancillary costs down
15.0%  Outpatient specialty down
24 April 2015, Michigan patient-centered medical home program shows statewide transformation of care YEAR 6

- 9.9% Decrease in adult ER visits
- 27.5% Decrease in adult ambulatory care sensitive inpatient stays
- 11.8% Decrease in adult primary care sensitive ER visits
- 8.7% Decrease in adult high-tech radiology usage
- 14.9% Decrease in pediatric ER visits
- 21.3% Decrease in pediatric primary-care sensitive ER visits

4,022 primary care doctors at 1,422 practices around the state in its sixth year of operation. These practices care for more than 1.2 million BCBSM members.
Payment reform requires more than one dial

Fee for...

health  value  outcome  process  belonging  service  satisfaction
Nearly 1/3 traditional Medicare tied to alternative reimbursement models—such as Patient Centered Medical home (PCMH)/ accountable care organizations (ACOs) or bundled payments—by the end of 2016 --- 50% by end 2018

And end of 2018 90% of traditional Medicare payments to quality or value through programs such as the Partnership for Patients Hospital, Value Based Purchasing and the Hospital Readmissions

Senate 92 to 8

https://www.youtube.com/watch?v=UY088YyQ6uA
Driving factor 1: **Unsustainable Cost** (USA 2012)
Driving factor 2: Data
Leveraging Watson for Knowledge- and Data-Driven Insights: Support 
**business continuity and growth**

- Medical literature
- Clinical guidelines
- Key textbooks
- Social determinants

- Claims data
- Health risks & behaviors
- Community-based data
- HR workforce data

---

**WATSON**

Published Knowledge

**Behcet's Disease**
- 45%

**Sarcoidosis**
- 32%

**Lyme Disease**
- 1%

---

**Observational Data**

Patient Care & Insights

---

Closing the **translational knowledge gap**

Enabling new **personalized and population health** insights

**Knowledge/Data-driven Insights for Better Health Decisions and Prevention of the Next 20% Who Could Cost 80%**

NOND-1162025-0001
VALUE BASED CARE COMPONENTS

Risk Analytics
- Actuarial Cost Analytics
- Contract Management
- Quality and cost reporting

Practice Analytics
- Physician Efficiency profiles
- Episode Efficiency profiles
- Drug profiles
- Cost of care analysis
- Imaging
- Leakage

Case Management
Manage high-cost patients (top 5%)
- Predictive modeling
- Patient risk stratification
- Readmissions
- ER usage
- Medication management
- Referral management

Population Management
Manage entire population
- Patient Stratification
- Preventive/Chronic gaps
- Visit compliance
- Rx / Lab compliance
- Self management
- ER, Hospital, Readmissions

Data warehouse IBM Power
IBM data Platform
Driving factor 3: Communication
Smart Integration, Customization, and Engagement:

Improve the overall health and vitality of our employees and their families

5 Dimensions of Health:
- Physical
- Mental
- Financial
- Social
- Purpose
Practice transformation away from episode of care

Master Builder

Preventive medicine
Chronic disease monitoring
Medication refills
Acute care
Test results

Doctor

Case Manager
Behavioral health
Medical Assistants
Nursing

Source: Southcentral Foundation, Anchorage AK
New model of care – putting the patient first

Healthcare Support Team

Case Manager

Chronic disease monitoring

Chronic disease compliance barriers

Acute mental health complaint

Behavioral health

Medical Assistants

Test results

Medication refills

Acute care

Preventive medicine

Source: Southcentral Foundation, Anchorage AK

© 2015 IBM Corporation
Future healthcare transformation

- Data driven
- Every person has a plan
- Team based
- Managing a population down to the individual
<table>
<thead>
<tr>
<th><strong>Today’s Care</strong></th>
<th><strong>PCMH Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those making appointments to see me</td>
<td>Our patients are the population community</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs with or without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory/skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations centre on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Source: Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
Defining the care centered on the patient

- Superb access to care
- Patient engagement in care
- Clinical information systems, registry
- Care coordination
- Team care
- Communication/ Patient Feedback
- Mobile – easy to use and available information
Benefit redesign – Patient engagement
Different strategies for different Healthcare spend segments

- Those with severe, acute illness or injuries
- Those with chronic illness
- Those who are well or think they are well

% Total healthcare spend vs. % of members
PCMH 2.0 in action

Community Care Team

- Nurse Coordinator
- Social Workers
- Dieticians
- Community Health Workers
- Care Coordinators

Public Health Prevention

HEALTH WELLNESS

A coordinated Health System

Health IT Framework

Global Information Framework

Evaluation Framework

Operations

Hospitals

Specialists

Public Health Prevention

PCMH

PCMH

PCMH

Smarter Healthcare
Call & Check Providing support and care for all in the community
Principles -- to guide Person and Community Centered Care:

1. Every patient should be respected as an expert in herself/himself.
2. The patient’s goals related to health and health care should be elicited, explored, identified, clarified.
3. Achieving these goals should be the focus of care provided.
4. All encounters should be conducted in a collaborative manner.
5. A key part of our work is to promote patient engagement and motivation.
6. Both patient and clinician should suggest interventions.
7. Those suggested by clinicians should always be based on the best available evidence.
8. Transparency is essential; areas of uncertainty should be disclosed.
9. Clinicians (and patients) should maintain a healthy respect for the harms that health care interventions may cause.
10. Shared decision-making should be the “default” approach to clinical decisions.
11. Clinicians are responsible for creating opportunities for shared decision-making; patients should make decisions informed by the relevant medical facts and their own values and preferences.
12. It is the clinician’s responsibility to fully inform patients of all information needed to participate in clinical decisions.
13. Medical information should be communicated in a manner that is fully understood by the patient.
14. Clinical encounters should be approached as a dialog between two experts: the clinician who has medical knowledge and expertise and the patient who is an expert in herself/himself and has a unique set of personal and cultural values and preferences.
15. Patients don’t care how much you know until they know how much you care.
16. Listen – generously and with compassion.