Patient-Centered
Primary Care
COLLABORATIVE

The Results Are In: An Overview of Key Findings from PCPCC's Annual Report

January 30, 2014

Speakers:
Marci Nielsen, PhD, MPH
J. Nwando Olayiwola, MD, MPH

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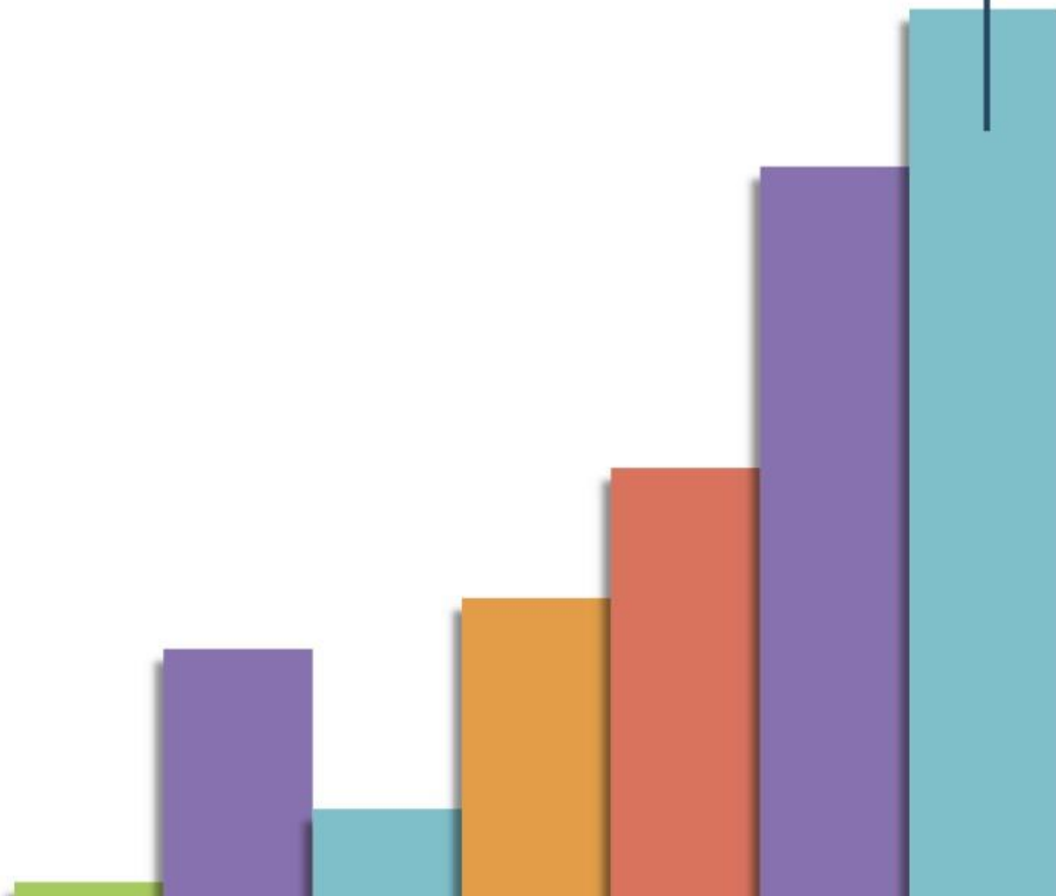

The Patient-Centered Medical Home's Impact on Cost & Quality:

An Annual Update of the Evidence, 2012-2013

January 2014

Authors

Marci Nielsen, PhD, MPH

Chief Executive Officer, PCPCC

J. Nwando Olayiwola, MD, MPH

Associate Director, Center for Excellence in Primary Care; Assistant Professor, Department of Family and Community Medicine, University of California, San Francisco

Paul Grundy, MD, MPH

President, PCPCC; Global Director, Healthcare Transformation, IBM

Kevin Grumbach, MD

Professor and Chair, Department of Family and Community Medicine; University of California, San Francisco

Lisa Dulsky Watkins, MD

Former Associate Director, Vermont Blueprint for Health

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Reviewers

Melinda Abrams, MS
Vice President, Health Care Delivery System Reform; *The Commonwealth Fund*

Asaf Bitton, MD, MPH
Instructor, Division of General Medicine, *Brigham and Women's Hospital*; Instructor, Department of Health Care Policy, *Harvard Medical School*

Mark Gibson
Director, Center for Evidence-Based Policy; *Oregon Health & Science University*

Bruce Landon, MD, MBA, MSc
Professor of Health Care Policy, *Harvard Medical School;* Professor of Medicine, Division of General Medicine and Primary Care; *Beth Israel Deaconess Medical Center*

Len Nichols, PhD
Director, Center for Health Policy Research and Ethics; *George Mason University*

Kavita Patel, MD
Managing Director for Clinical Transformation and Delivery; Engelberg Center for Health Care Reform; Fellow, Economic Studies *The Brookings Institution*

Mary Takach, MPH, RN
Senior Program Director; *National Academy for State Health Policy*

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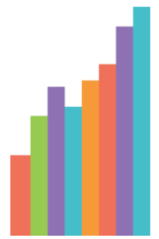
Description of Methods



- Examined medical home/PCMH studies published between August 2012 and December 2013
  - Peer-reviewed scholarly articles
  - Industry reports
- Explored relationship between “medical home/PCMH” model of care and Triple Aim outcomes
  - Predictor variable: “Medical home” or “PCMH”
  - Outcome variables: Cost & utilization; care experience (access & patient satisfaction); health outcomes (population health & preventive services)
- Resulted in 13 peer reviewed (academic) studies, and 7 industry reports

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13 Peer-Reviewed (Academic) Studies

- Alaska Southcentral Foundation
- Colorado Multi-Payer PCMH Pilot
- BlueCross BlueShield Michigan
- Military Health System
- Veterans Health Administration
- New Hampshire Citizens Health Initiative
- Horizon BlueCross BlueShield
- EmblemHealth – New York
- WellPoint - New York
- UPMC Health Plan
- Rhode Island Chronic Care Sustainability Initiative
- University of Utah
- Group Health Cooperative

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7 Industry generated Reports

- BlueCross BlueShield Alabama
- Connecticut Health Enhancement Program
- Horizon Blue Cross Blue Shield
- BlueCross BlueShield Michigan
- CareFirst BlueCross BlueShield
- Oregon Coordinated Care Organizations
- Highmark PCMH Pilot

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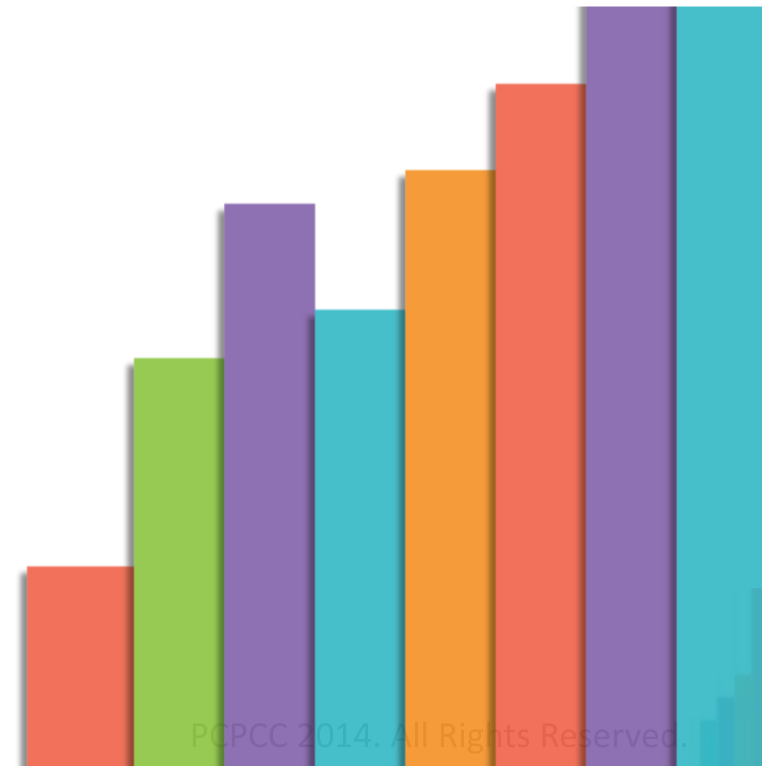
Key Point #1:

PCMH evaluations report improvements across a broad range of clinical and financial outcomes



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PCMH **Peer Reviewed** Outcomes

- 61% of studies report cost reductions
- 61% report fewer ED visits
- 31% report fewer inpatient visits
- 13% report fewer readmissions

Cost & Utilization

- 31% of studies report improved access
- 23% of studies report improved patient satisfaction

Care Experience

- 31% of studies report increase in preventive services
- 31% report improvements in population health

Health Outcomes

PCMH **Industry Generated** Outcomes

- 57% of studies report cost reductions
- 57% report fewer ED visits
- 57% report fewer inpatient visits
- 29% report fewer readmissions

Cost of Care Utilization

- 14% of studies report improved access
- 14% of studies report improved patient satisfaction

Care Experience

- 29% of studies report increase in preventive services
- 29% report improvements in population health

Health Outcomes

The Challenge of Studying the PCMH

- Right metrics?
  - Gap in **clinician satisfaction measures** – tied to workforce needs
  - Need for better/more **patient satisfaction measures** of self-reported health status/well-being
  - Measures need to account for **patient diversity**
  - Need for standard **core measures – including behavioral health integration**
- Right methods?
  - Study designs appropriate for investigating complexity of health system reforms
  - Recognition that the model/philosophy is evolving

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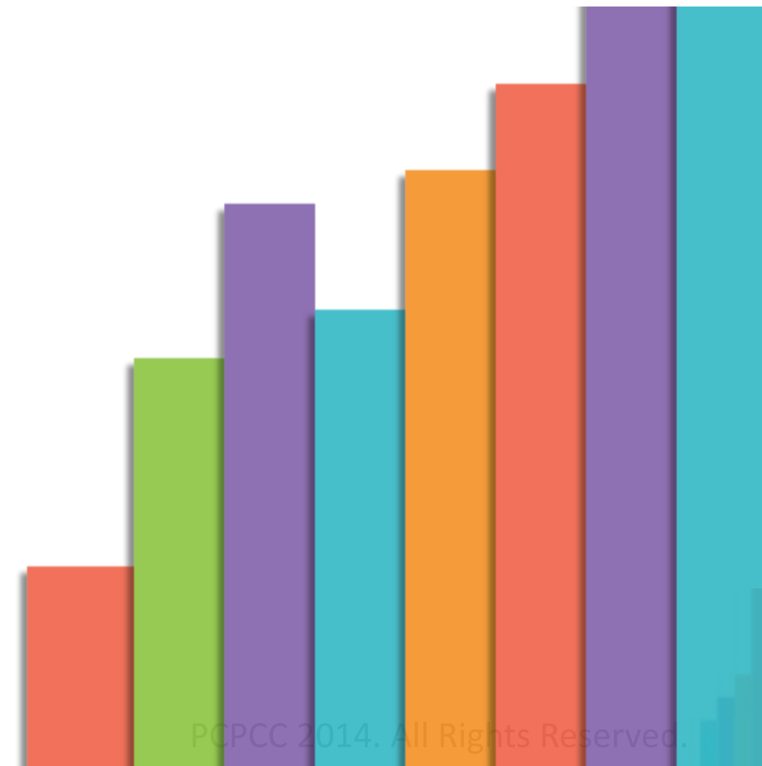
Key Point #2:

PCMHs play a critical role in delivery system reform, including ACOs and the medical neighborhood



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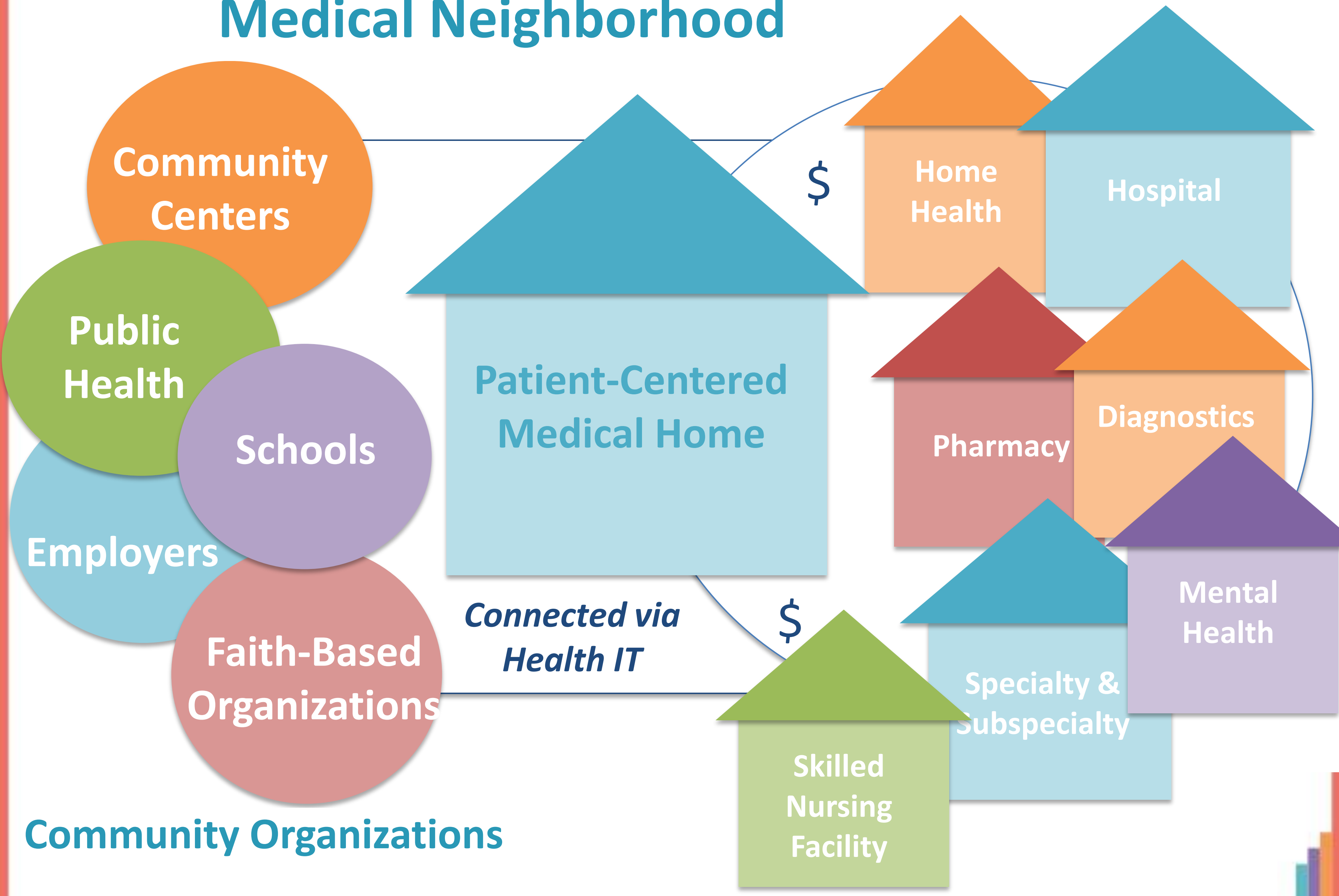
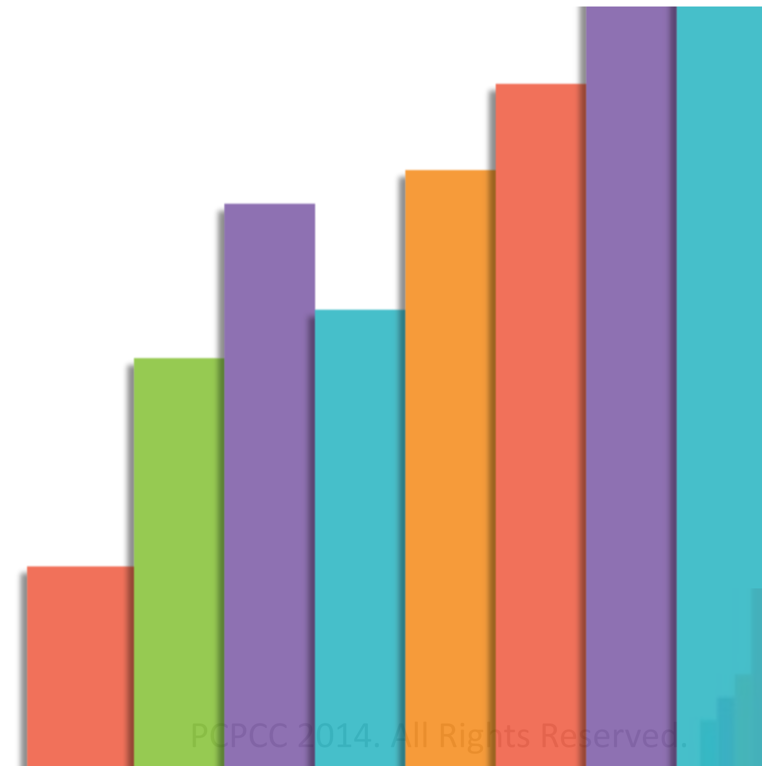
PCMH: Foundation to ACOs & the Medical Neighborhood



Key Point #3:

Significant payment reforms continue to incorporate the PCMH



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Payment Reform Imperative

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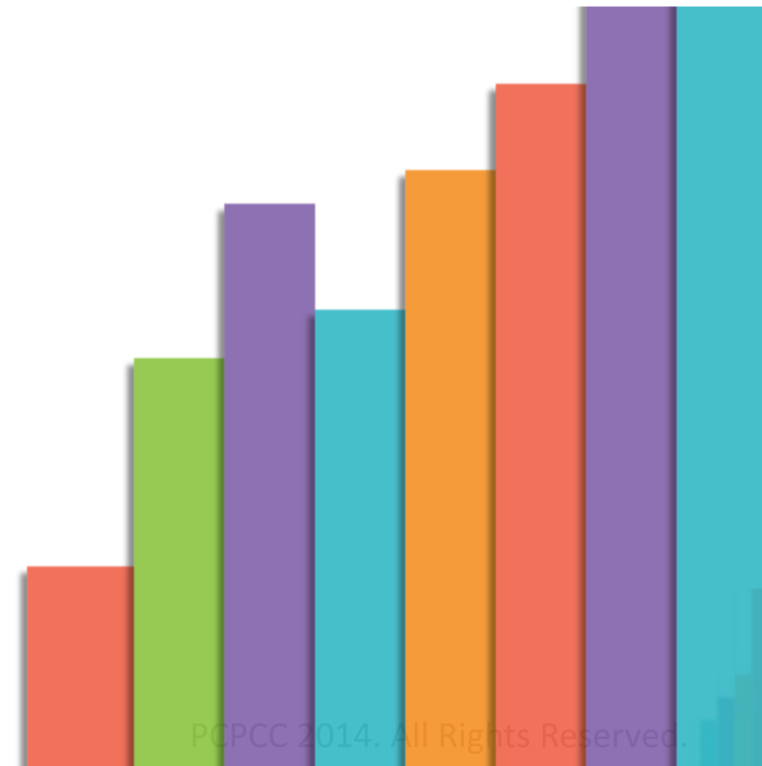
The Year in Review: Case Study Snapshots



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Veterans Health Administration Patient Aligned Care Team

National program
5 million patients

PCMH Strategies

- Optimize workflow and coordinate care through the use of an interprofessional "teamlet" model
- Enact advanced scheduling, such as same-day appointments
- Add phone consults and group appointments

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

Rosland, A.M., Nelson, K., Sun, H., Dolan, E.D., Maynard, C., Bryson, C., Stark, R., Schectman, D., (2013). The Patient-Centered Medical Home in the Veterans Health Administration. American Journal of Managed Care. 1-4.

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BlueCross BlueShield of Michigan Physician Group Incentive Program

Michigan
3 million patients

PCMH Strategies

- Develop patient registries to track and monitor patients' care
- Offer 24-hour patient access to a clinical decision-maker through
  - extended office hours
  - telephone access
  - a linkage to urgent care
- Provide online patient resources that allow for electronic communication and greater patient access to medical information

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

Blue Cross Blue Shield of Michigan. Patient-Centered Medical Home Fact Sheet. July 2013. Retrieved from http://www.valuepartnerships.com/wp-content/uploads/2013/07/2013-PCMH-Fact-Sheet.pdf.

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UPMC Health Plan Medical Home Pilot

Pennsylvania
23,390 patients

PCMH Strategies

- Practice-based nurses provide care management
- Create telehealth options for care managers to connect to patients when in-office visits are not possible or necessary
- Offer incentives to payers to enter into PCMH contracts

Results

- 2.6% reduction in total costs
- 160% ROI

- 2.8% fewer inpatient admission

- 18.3% fewer hospital readmissions

- 6.6% increase in patients with controlled HbA1c

- 23.2% increase in eye exams
- 9.7% increase in LDL screenings

Rosenberg, C.N., Peele, P., Keyser, D., McAnallen, S., & Holder, D. (2012) Results from a patient-centered medical home pilot at UPMC Health Plan hold lessons for broader adoption of the model. Health Affairs. 31(11).

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CareFirst BlueCross BlueShield Maryland

Maryland
1 million patients

PCMH Strategies

- Use local care coordination teams to track high-risk members
- Create an infrastructure for nursing support, easily-accessible online tools and data, and targeted health programs
- Offer increased reimbursements to physicians based on performance in the program

Results

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

- 3.7% higher quality scores for panels that received incentives
- Quality scores for PCMH panels rose by 9.3% from 2011 to 2012

CareFirst Blue Cross Blue Shield. Patient-centered medical home program trims expected health care costs by $98 million in second year. Press Release, June 2013. Retrieved from https://member.carefirst.com/wps/portal/!ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP0os3hLbzN_Q09LYwN_Fw9DA09fi1BHj6AgQwNHM_2CbEdFANmphzQ!/?WCM_GLOBAL_CONTEXT=/wcmwps/wcm/connect/content

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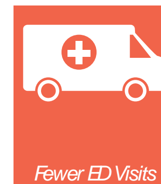
Oregon Health Authority Coordinated Care Organizations (CCOs)

Statewide Medicaid program
600,000 patients

PCMH Strategies

- Establish a primary care infrastructure that includes 450 PCMH practices and clinics
- Increase the use of outpatient care to promote prevention
- Increase well-care visits to adolescents to reduce unnecessary ED visits
- Provide follow-up care to patients within 7 days of being discharged

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 capital health spending growth by >1%

Oregon Health Authority. (2013). Oregon's Health System Transformation: Quarterly Progress Report. Retrieved from http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf.

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Take Home Points

- ✓ PCMH evaluations over the past year reported **significant improvements** across a broad range of **clinical and financial outcomes**

- ✓ The PCMH is playing an increasingly critical role in **delivery system reform**, including ACOs and the medical neighborhood

- ✓ Significant **payment reforms** continue to incorporate the PCMH

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