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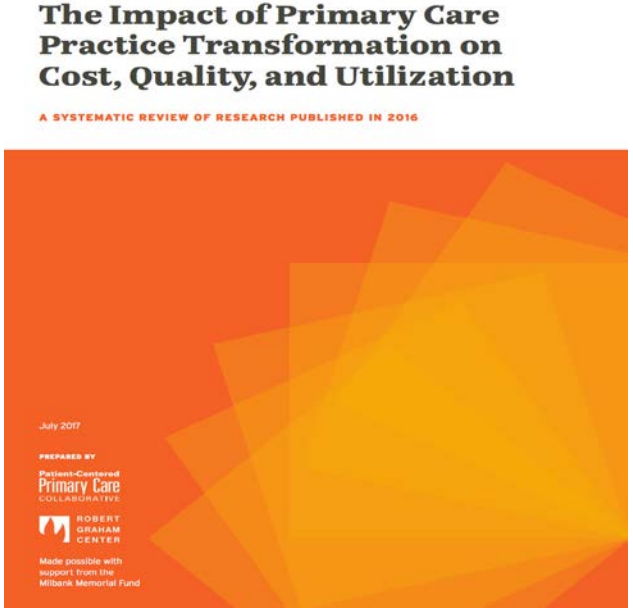


# The Impact of Primary Care Practice Transformation on Cost, Quality and Utilization

August 16, 2017

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# Welcome & Announcements

- Welcome – Ann Greiner, PCPCC President & CEO
- 2017 Evidence Report -- PCMH and other models of advanced primary care; attributes captured in Shared Principles
- Shared Principles – opportunity to sign on
  - www.pcpcc.org/about/shared-principles
- List of Shared Principle signatories released at the PCPCC Fall Conference **Oct. 11-12** in Washington, DC
- *Innovations in Primary Care: Putting the Shared Principles into Practice* Registration: www.pcpccevents.com
- Housekeeping – to ask questions, please send them via chat box

# Transforming Clinical Practice Initiative (TCPI)

**CMS-funded national initiative that supports over 140,000 clinicians** in sharing, adapting and further developing their comprehensive quality improvement strategies.

As a **Support & Alignment Network** (SAN), the PCPCC offers technical assistance to improve person and family engagement (PFE) in the practice by providing:

- Coaching calls with PFE subject matter experts
- Customized virtual trainings and webinars
- In-person workshops
- Assistance to clinicians to develop community partnerships with local YMCAs

**For more information, visit www.pcpcc.org/tcpi**


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PLANETREE

the YMCA

# The Robert Graham Center

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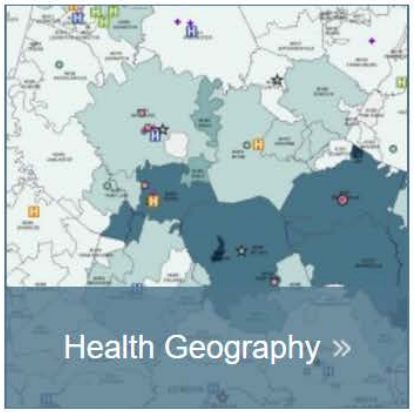





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# The Graham Center Team

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# The Report Team

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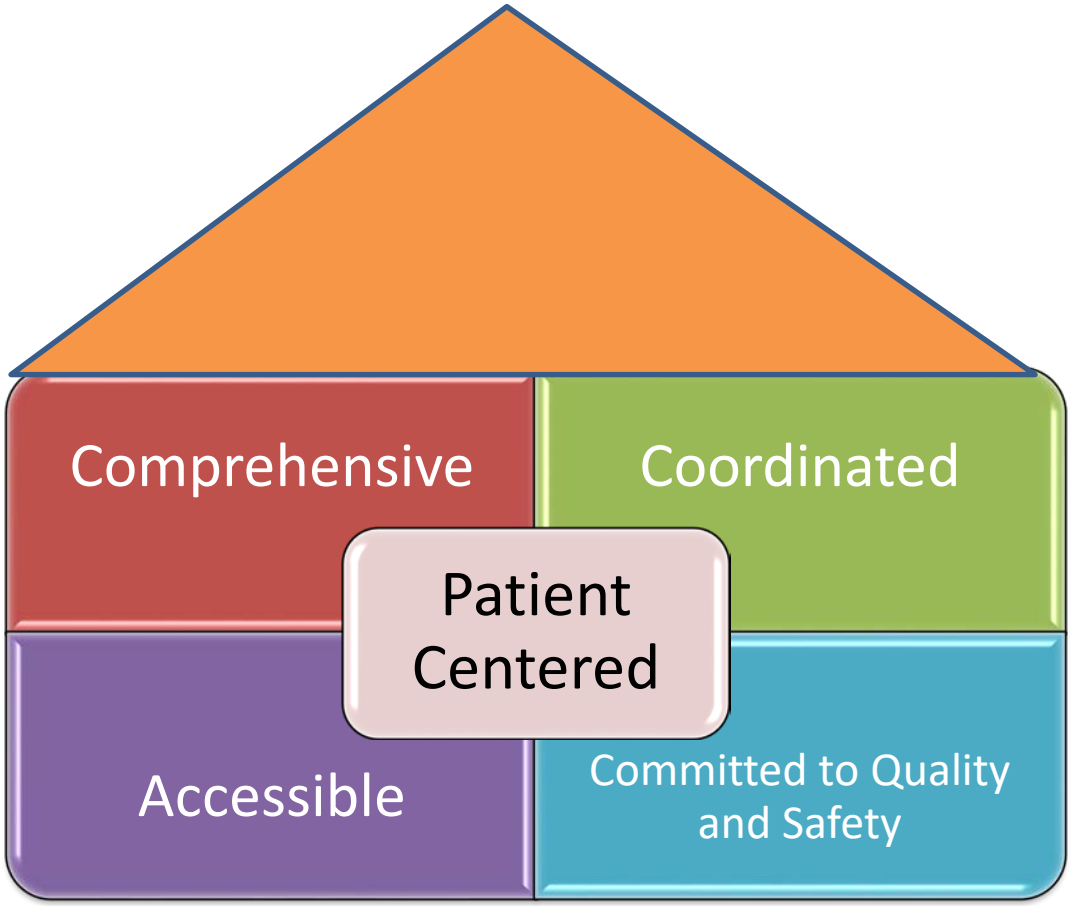
# The Patient Centered Medical Home

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# The Report

**Our Task**

- Review of the literature published about the PCMH and advanced primary care in 2016
- Focus on Cost, Utilization and Quality

**What's Different this Year**

- New authors
- Broader Scope of Research
- More rigorous search criteria
  - Peer- reviewed literature(45)
  - Grey Literature with a rigorous methods section

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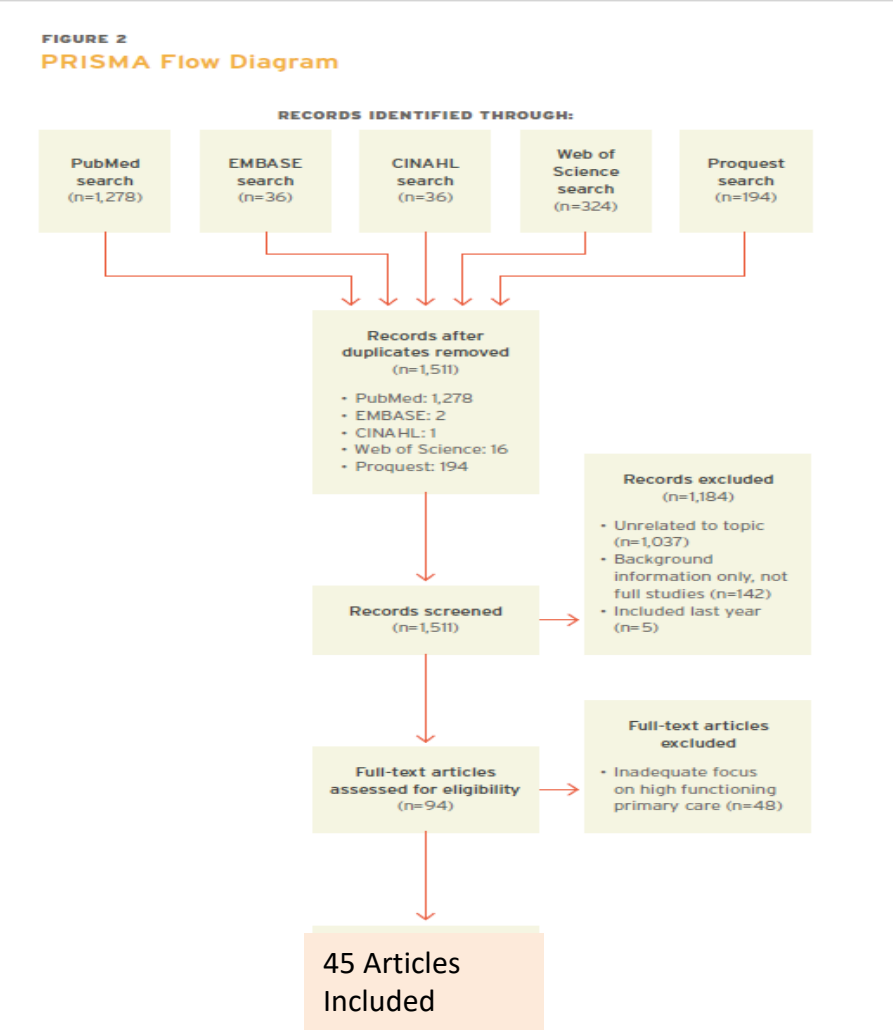
# Literature Review Approach

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# Three Categories of Articles

- PCMH Implementation Studies (17)- *PCMH vs. traditional care.*
- Features of PCMH Care Delivery Studies (15)- *Non-PCMH or not mentioned if PCMH but with PCMH like features as compared to traditional care.*
- PCMH Enhancement Studies (13)- *Mature PCMH's that study the impact of specific PCMH components(i.e.) team based care, telehealth)*

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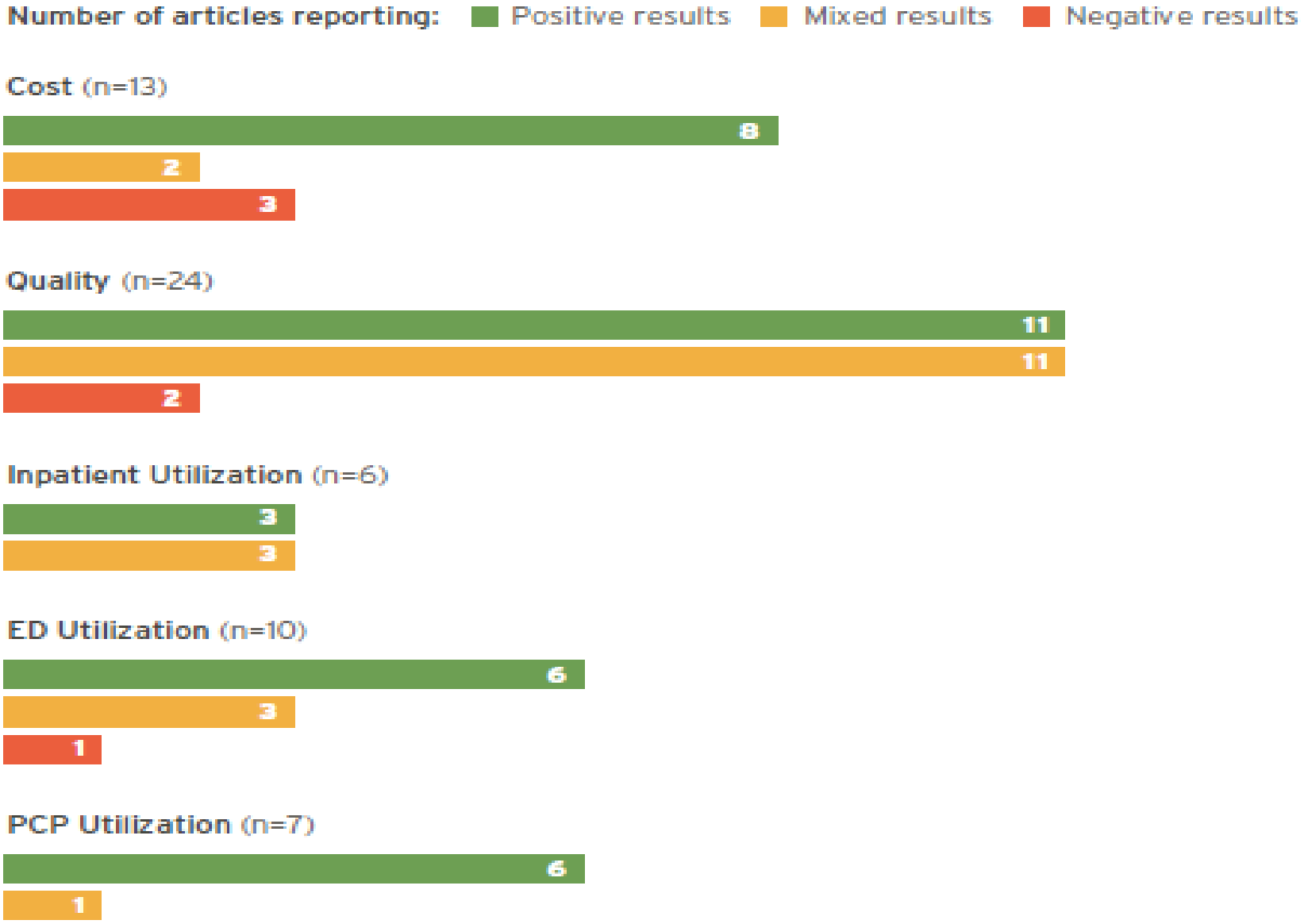
# Summary of Outcomes: Peer Reviewed Articles



# Peer Reviewed Studies-Cost

| Type of Study | Results |
| --- | --- |
| PCMH Implementation Study (7) | Overall positive results<br>• Increased savings over time and with more chronic conditions |
| Features of PCMH Care Delivery Study (1) | Negative<br>• Only one study and limited patient population |
| PCMH Enhancement Study (5) | Overall positive results<br>• Decreased in 3 studies, unchanged in 2 |

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# Peer Reviewed Studies-Quality

| Type of Study | Results |
|---|---|
| PCMH Implementation Study (7) | Mixed |
| Features of PCMH Care Delivery Study (10) | Mixed |
| PCMH Enhancement Study (8) | Mixed with a trend towards positive* |

All 3 studies looking at the patient experience reported positive findings

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# Peer Reviewed Studies- Utilization

| Type of Study | Results |
|---|---|
| PCMH Implementation Study (11) | Mixed<br>• Those that reported on PCP visits showed increases<br>• Many but not all decreased ED visits<br>• Only 1 of 11 studies showed a decrease in inpatient hospitalization |
| Features of PCMH Care Delivery Study (7) | Mixed<br>• Those that reported on PCP visits showed increases<br>• Many but not all decreased ED visits<br>• No difference in the studies that looked at inpatient |
| PCMH Enhancement Study (7) | Mixed, trend towards positive |

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# Grey Literature

Comprehensive Primary Care Initiative (Year 3 report)

- 4 year multi-payer initiative started in 2012
- Included 7 US regions
- Offered population-based care management fees and shared savings to support core primary care functions

Multi-Payer Advanced Primary Care Practice

(Year 3 report, thematic analysis)

- 3 year multi-payer initiative started in 2011
- Began with 8 states, 5 of the 8 continued through 2016
- Offered a monthly care management fee for beneficiaries in advanced primary care practices

# CPCI Results

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| **Cost** (With care management fees) | Decreased by 2%*** | Decreased by 1% | No net savings . Increased cost in Ohio/Kentucky** |
| **Utilization** | | | |
| ED | Decreased by 1% | Decreased by 1% | Decreased by 2%*** |
| Hospitalizations | Decreased by 2% | Decreased by 2% | Decreased by 1% |
| **Quality** (Urine protein testing in diabetics)**** | Increase by 0 .7% | Increase by 1 .6%*** | Decrease by 0 .1% |

**Shared-savings calculations (different than the evaluation) showed savings in Arkansas, Colorado, Oklahoma and Oregon .

*** Statistically significant result . All other reported results not statistically significant to P values < 0 .05% .

**** Among quality of care process measures urine protein testing in diabetics was the only measure that showed a statistically significant change

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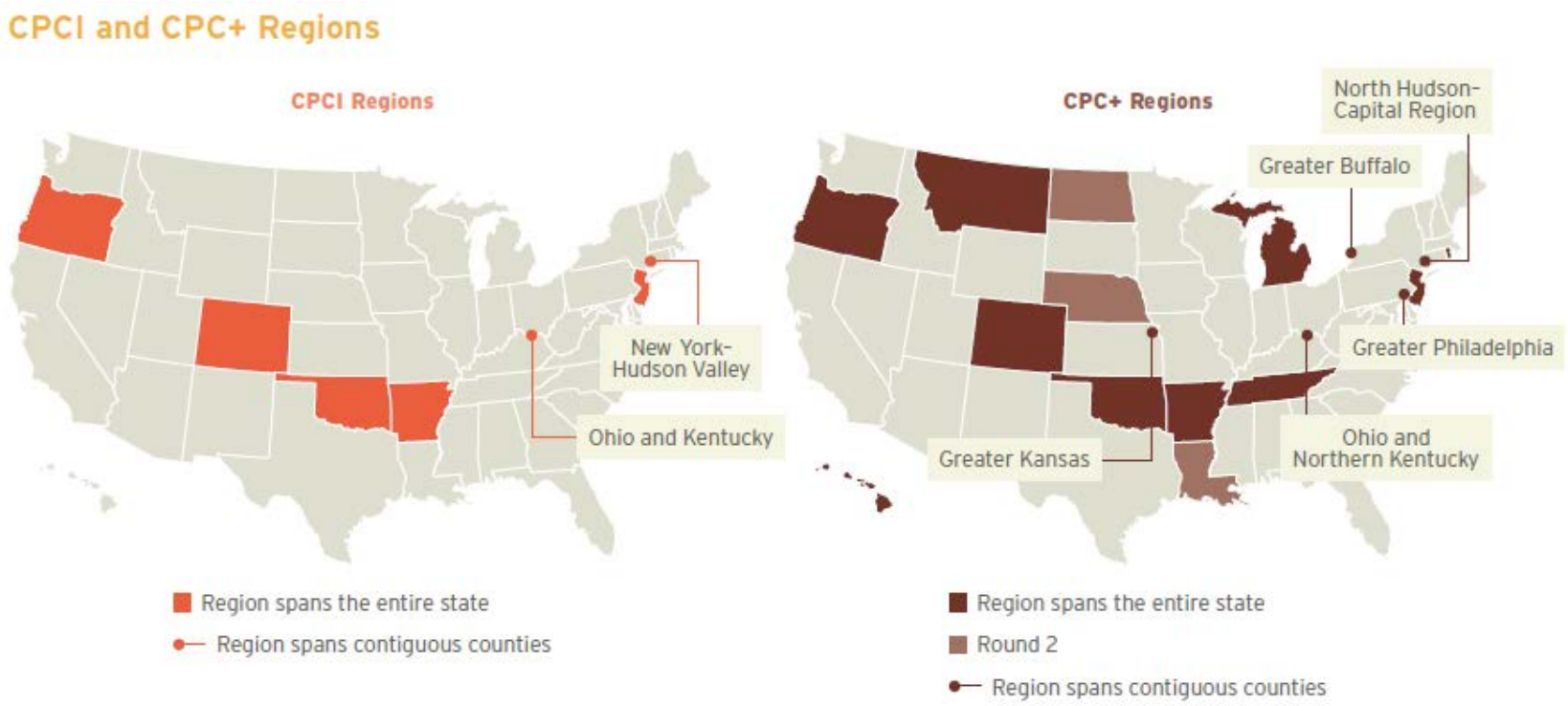
# Comprehensive Primary Care Initiative

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# CPCI States

**FIGURE 8**
**STATE SPOTLIGHT**
## Colorado

**Program Name**
Accountable Care Collaborative

**Program Description**
1) Created seven regional care collaborative organizations (RCCO's) that are responsible for coordinating patient care and connecting members with non-medical services 2) Primary care medical providers (PCMPs) contract with RCCO's to become medical homes for Medicaid members in the collaborative. 3) RCCOS's and PCMP's receive incentive payments based on performance on key metrics

**Payment for Programs**
CPCI funding, Medicaid and Grant funding

**Program Outcomes**
**Cost:** Reduced costs about $60 per member per month (PMPM) on adults and $20 PMPM on children as compared to eligible members who were not enrolled in an ACC over the same time period. In dual eligible beneficiaries this cost savings was about $120 PMPM. *

**Utilization:** well child checks for children ages 3-9 increased from 20.6% for clients who were enrolled less than 6 months to 43% for those enrolled for 7 months or more. They also found that follow up care after hospital discharge increased from 41.2% to 49.4% the longer the patient was enrolled in the program. As time enrolled in the program increased, utilization of ER services decreased by 5% and 30 day all-cause readmissions decreased. **

**Quality:** No difference in key performance indicators

* Cost savings even shown when controlling for CPCI and grant funding
** Significance testing not done or not reported

**FIGURE 11**
**STATE SPOTLIGHT**
## Oregon

**Program Name**
Patient Centered Primary Care Home

**Program Description**
1) Provide financial support for practice transformation 2) Identify and disseminate best practices of a medical home 3) encourage individuals who are covered by Oregon's Health Plan to enroll in PCPCH clinics

**Payment for Program**
CPCI funding and Medicaid

**Program Outcomes**
**Cost:** Reduced total service expenditures per person by 4.2%, apx $41 per person per quarter

**Utilization:** Increase in primary care and pharmacy services, and a reduction in all other service types. Of these, only total, specialty and inpatient care decreases were statistically significant

**Quality:** Not mentioned

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# MAPCP Results

**Results:**

- Thematic in nature
- Care management had most significant impact on utilization and expenditures
- Reaching out to recently hospitalized patients important
- Risk stratifying and allocating resources also important

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# MAPCP State

**FIGURE 10**
**STATE SPOTLIGHT**
**Minnesota**

**Program Name**
Health Care Home Initiatives (HCHI)

**Program Description**
1) Provide financial incentives for clinics to transform 2) Developed a learning collaborative for participating clinics 3) Developed certification standards and transformation assistance

**Payment for Program**
MAPCP

**Program Outcomes**
**Cost:** Demonstrated significant savings on their Medicare, Medicaid and Dual eligible beneficiaries as compared to non-healthcare home patients in the same time period

**Utilization:** 1) Increase in emergency department and skilled nursing home use relative to non-Health Care Homes. 2) Significant decreases in the use of inpatient hospital services. 3) Slight decrease in the use of prescription drugs. 3) Decreased hospital based outpatient visits* 4) Increase in office based outpatient visits

**Quality:** 1) better adjusted quality of care for patients with diabetes, lipid screening, asthma, depression and colorectal cancer screening 2) The largest and most significant findings were in optimal asthma care 3) Patient experience was unchanged

* Generally more expensive visits and usually comprise of specialty visits rather than primary care visits.

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# Conclusion:

The analysis shows positive overall results in terms of cost, quality and utilization but not always uniformly

- Patients with greater comorbidity and systems with these patients may show greater early strides
- Transformed and transforming practices need time to mature before significant improvements can be achieved.
- We can't apply a one-size- fits-all approach to the implementation and evaluation of practice transformation
- Mixed results seen in this review may be due to a positive spill- over effect of transformed practices on practices that have yet to transform.

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# Policy Implications

- Overarching: Results take time and there is no silver bullet
- CMMI drives innovation – Demonstrating an ability to incorporate learnings and to partner w/the private sector
- Public sector as payer – Can lead in providing high performing primary care as a key, low cost benefit
- MACRA – A-APMs that support comprehensive care, including primary care as bedrock; support for PCMH within MIPs

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# Expert Reactions

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# Questions?

Please type questions in the question box in the webinar control panel

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