

# Agenda

- Why are changes in the healthcare delivery system critical for reform?
- What is a Patient Centered Medical Home (PCMH)?
- Is there evidence this model reduces healthcare costs and improves quality?
- Who supports the PCMH?
- What legislators can do-

# Adoption of the Patient Centered Medical Home – why critical?

- 75% of our costs are related to chronic disease and growing
- Having insurance does not mean you have the infrastructure to deliver the care needed to improve health or reduce costs- ask Massachusetts
- Evidence is clear that coordinated care throughout the system- centered around primary care reduces costs and improves quality

# Adoption of the Patient Centered Medical Home – why critical?

But- the US health system is geared and aligned financially to reward acute episodic care

- more volume of care and procedures rewarded
- with no payment or system for coordination of care
  - between various doctors
  - for education of the patient about lifestyle choices, management of chronic conditions, medications, or social needs
- with out-of-pocket costs not aligned to encourage use of primary and preventative care services, coordinated services, or behavioral health

# So - Let's Look at Solutions...

## How About Changing the Healthcare System

- What if- the US health system is geared and aligned financially
- to focus on the person (patient centric) and all of their needs, instead of just one problem at a time
  - usually in a longer office visit in coordination with a primary care doctor
  - with payments and systems for a team coordination of care
    - between various doctors, nurses, pharmacists, behavioral health, etc.
    - to educate patients about prevention and lifestyle choices, their conditions, and any medications
    - in a culturally and medically literate fashion to meet the patients health, medical, and social needs

## TODAY'S CARE

My patients are those who make appointments to see me



Care is determined by today's problem and time available today



Care varies by scheduled time and memory or skill of the doctor



I know I deliver high quality care because I'm well trained



Patients are responsible for coordinating their own care



It's up to the patient to tell us what happened to them



Clinic operations center on meeting the doctor's needs



## MEDICAL HOME CARE

Our patients are those who are registered in our medical home

Care is determined by a proactive plan to meet patient needs with or without visits

Care is standardized according to evidence-based guidelines

We measure our quality and make rapid changes to improve it

A prepared team of professionals coordinates all patients' care

We track tests & consultations, and follow-up after ED & hospital

A multidisciplinary team works at the top of our licenses to serve patients

# The Patient Centered Medical Home (PCMH)

- The Patient Centered Primary Care Collaborative
  - Four largest Primary Care Organizations (AAFP, AAP, ACP, and AOA)
  - Large employers- IBM, Fed Ex, Dow, etc.
  - Health Plans- BCBSA, Aetna, Cigna, UHC, Wellpoint (all major national plans)
  - Pharmaceuticals, PBMs, others- GSK, Caremark, etc.
  - Board of Advisors- includes AARP, Common Wealth Fund (advocacy), NCQA, NBGH, NBCH, etc

**All aimed at Changing the Healthcare System  
to make the Patient Centered Medical Home a Reality**

# The Patient Centered Primary Care Collaborative

- The Patient Centered Primary Care Collaborative is a **coalition** of over 650 major employers, consumer groups, health plans, unions, organizations representing primary care physicians, government, and other stakeholders who have joined ***to advance the patient centered medical home.***
- The Collaborative believes that, if implemented, the **Patient Centered Medical Home** will ***improve the health of patients and the health care delivery system while reducing costs.***

# Who Supports the Patient Centered Medical Home?

“Position: The National Business Group on Health (the Business Group), representing over 270 large employers who provide coverage for 55 million Americans, *believes that both the public and private sector should support and reward effective and efficient primary care.*

The Business Group supports the following principles for reforming the health care system:

- Primary care as foundational to a high quality, efficient and effective health care delivery system
- Payment policies that recognize the value of primary care and primary care like services
- Support the concept of an “advanced medical home” as appropriate

“The Healthcare Delivery System Should Be Focused on Primary Care”- National Business Group on Health- 11/14/07  
<http://www.businessgrouphealth.org/pdfs/primarycarepositionstatement.pdf>

# Who Supports the Patient Centered Medical Home?

The U.S. Chamber believes that “The health care payment and reimbursement system should evolve to follow the patient-centered medical home (PCMH) model of care in order to improve quality and efficiency in medical care....”<sup>1</sup>

“Many of the U.S. Chamber’s current focuses, such as wellness and prevention, transparency and value-based purchasing, and HIT implementation might all be furthered by the increased success of the PCMH”<sup>2</sup>

<sup>1</sup> US Chamber of Commerce Health and Retirement Priorities for the 111<sup>th</sup> Congress pg.7

<sup>2</sup> US Chamber of Commerce Employee Benefits Strategic Vision pg.28-29

# Who Supports the Patient Centered Medical Home?

*“Medical Homes and Community Health Teams: We have been a strong supporter of the concept of a patient-centered medical home as a promising approach to promote primary care and encourage not only care coordination throughout the care continuum but patient self-efficacy as well.”*

AARP-

June 11, 2009 Senate HELP Committee Testimony

# Who Supports the Patient Centered Medical Home?

“We are not guaranteed high-quality, efficient, and coordinated care, even when we pay more. Our current delivery system encourages inefficiencies and duplicative services. The system does not reward for the quality of care delivered, but rather pays for the amount of care provided. We can begin to address these challenges.

Gov. Jim Douglas, VT

NGA Chair 2009/10

# Who Supports the Patient Centered Medical Home?

“Vermont, for example, has successfully implemented comprehensive health reform that *incorporates aspects of high quality, coordinated care along with expanding coverage to the uninsured.* Our innovative Blueprint for Health initiative has developed *care teams that provide coordinated services through multiple providers.*”

We are changing the way we pay for care to encourage primary and preventive services, as well as sharing costs across hospitals and doctors to promote coordination.”

Gov. Jim Douglas, VT

NGA Chair 2009/10

CSG and NBCSL have passed resolutions endorsing the PCMH

# Evidence of Quality Improvement

- Primary care physician supply is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care.
- In both England and the United States, each additional primary care physician per 10,000 persons is associated with a decrease in mortality rate of 3 to 10 percent.<sup>1</sup>
- Patients with chronic diseases receive better overall care when supported by a Medical Home:
  - Patients with diabetes had significant reductions in cardiovascular risk;
  - Patients with congestive heart failure had 35% fewer hospital days;
  - Asthma and diabetes patients were more likely to receive appropriate therapy.<sup>2</sup>

# Evidence of Quality Improvement

- A Medical Home can reduce or even eliminate racial and ethnic disparities in access and quality for insured persons. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.<sup>3</sup>
- States that are more reliant on Primary Care have been cited that have far fewer ICU deaths and higher composite quality scores.<sup>4</sup>

# Evidence of Cost Reduction

- Recent studies estimate that if every American had access to a Medical Home, national health care expenditures would drop by 5.6% -- translating into a national savings of at least \$67 billion per year.<sup>5</sup>
- States which relied more on Primary Care have:
  - 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
  - Lower Medicare Spending (inpatient reimbursements and Part B payments).<sup>4</sup>

# EVIDENCE OF COST SAVINGS & QUALITY IMPROVEMENT

## Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions

### Group Health Cooperative of Puget Sound

- 29% Reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- Additional investment in primary care of \$16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients.

### Community Care of North Carolina

- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.

### Genesee Health Plan HealthWorks PCMH Model

- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

### Colorado Medicaid and SCHIP

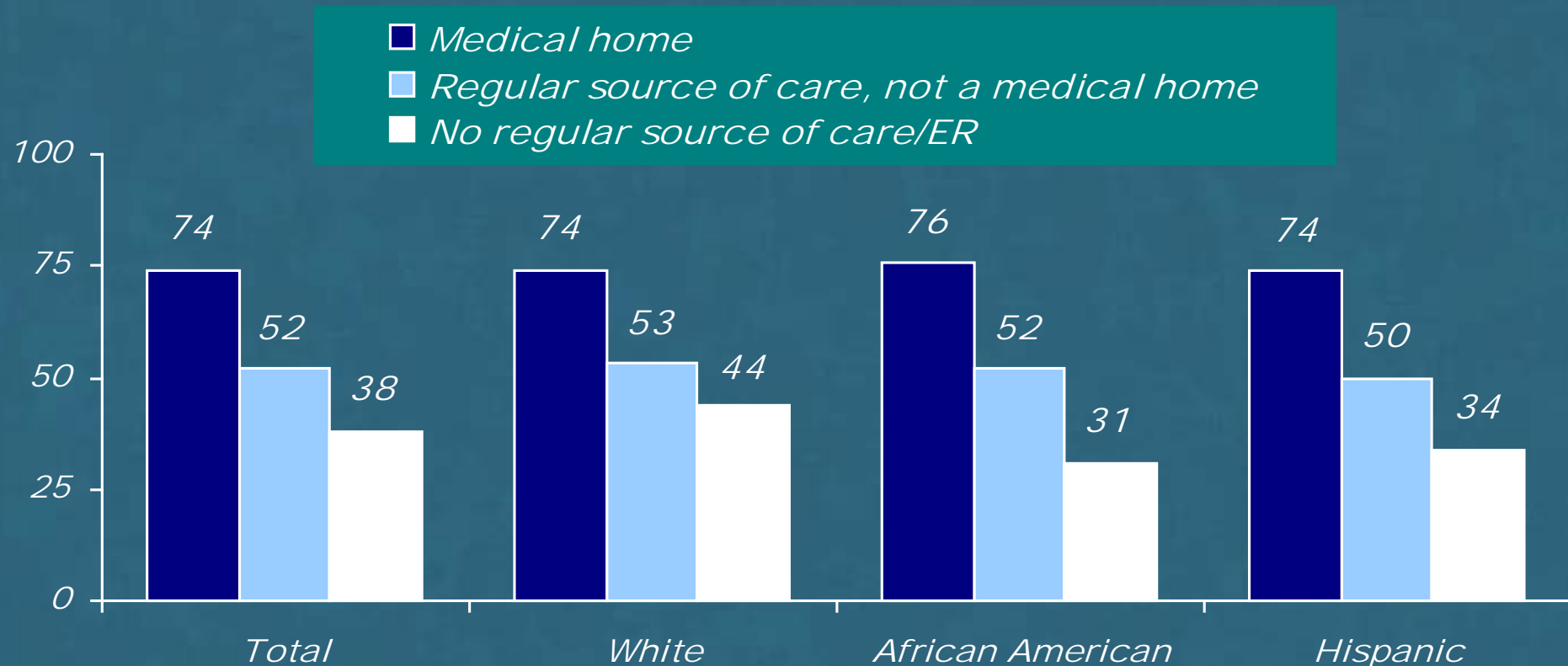
- Median annual costs \$785 for PCMH children compared with \$1,000 for controls, due to reductions in ER visits. and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).

### 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 \$1364 per patient and \$75,000 per Guided Care nurse deployed in a practice.

# Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.  
Source: Commonwealth Fund 2006 Health Care Quality Survey.

# Key Drivers for Advancing the PC-MH into Practice

- **The Payment System for Primary Care must be fundamentally changed!**
  - Coordination of care activities, disease management, and enhanced access (such as e-mail correspondence with patients) must be reimbursed
- **IT systems and practice infrastructure must change-** advanced EMR's, registries, interoperability of reports, e-prescribing, etc. must be in place to coordinate and deliver high quality care
- **Quality process assessments and outcomes must be standardized and transparent-ex. NCQA-criteria for advanced medical homes**

# Community Care of North Carolina - PCMH a Reality!!!

## Primary Goals

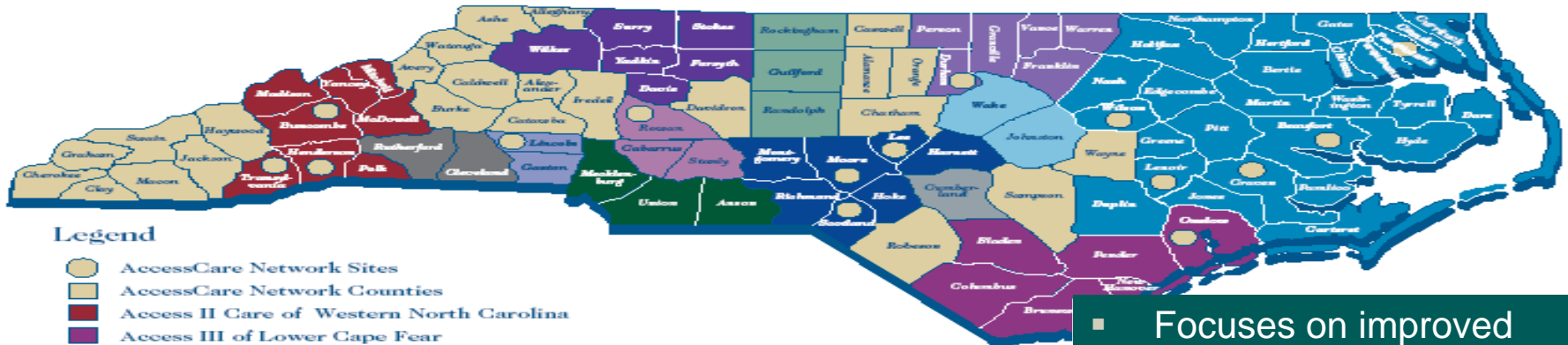
- Improve the care of the Medicaid population while controlling costs
- Develop Community based networks capable of managing populations in partnership with the State
- Develop the Medical Home Model Fully ( enhanced PCCM)

# Coordination of Care Results- Big Savings for North Carolina and Better Care for Patients!

NOW



## Community Care of North Carolina Access II and III Networks



### Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan

September 2008

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care and prevention
- 14 Networks with more than 4000 Primary Care Physicians (1300 medical homes)
- Over 900,000 enrollees

# Community Care of North Carolina - 2009

Each Network Now Has:

- Part- time paid Medical Director- role is oversight of quality efforts, meets with practices and serves on State Clinical Committee
- Clinical Coordinator- oversees the overall network operations
- Care Managers- small practices share/large practices may have their own assigned
- All networks have a PharmD to assist with medication management of high cost patients (MTM)

# North Carolina Medicaid State Fiscal Year 2004 Savings

Category of Service	Estimated Savings from Benchmark
Inpatient	\$142,085,680
Outpatient	\$51,865,028
Emergency Room	\$25,944,553
Primary Care, Specialist	\$45,498,709
Pharmacy	\$(15,526,996)
Other	\$(5,065,238)
<b>Totals</b>	<b>\$244,801,735</b>

# Why Did Pharmacy Costs Go Up?

- *“Underutilization of controller medications in asthmatics and lack of adherence to medications in patients with congestive heart failure were major contributors to ER visits and hospitalizations.”*

*Dr. Allen Dobson- Former NC Assistant Sec. of Health  
and State Medicaid Director*

# Community Care of North Carolina

## July 1, 2003 – June 30, 2004

- Cost - \$10.2 Million  
(Cost of Community Care Operations)
- Savings - \$124 million compared to SFY03
- Savings - \$225 million compared to FFS

*SFY 2005 and 2006 results \$231 million saved*

# Clinical Results Improve!

## Asthma

- 40% decrease in hospital admission rate
- 16% lower ED rate
- 93% received appropriate maintenance medications

## Diabetes

- 15% increase in quality measures

*Pilots now include the addition of the Aged, Blind, and Disabled and Medicare (646 waiver)!*

# Patient Centered Medical Homes in the US

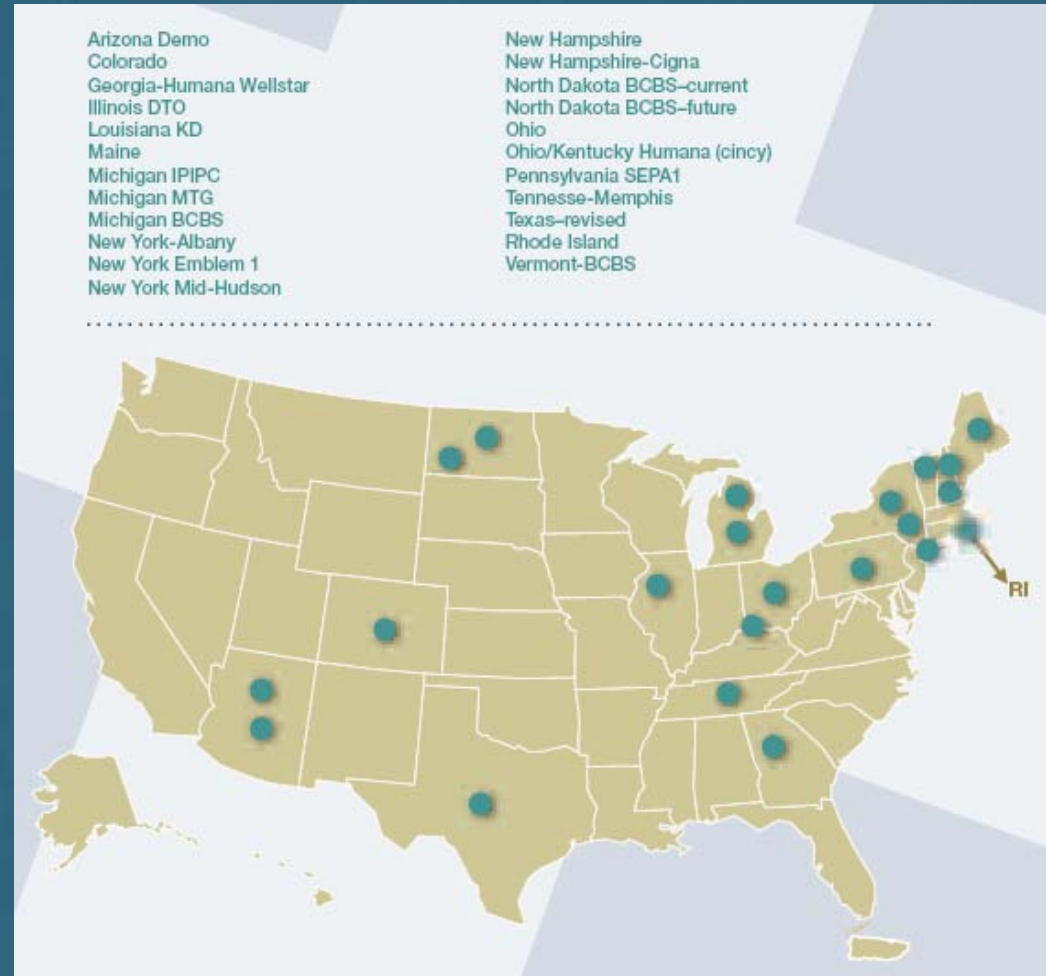
- Mid Hudson- 8 county NY Project-
  - NY Dept of Health- \$5 million, IBM partnering, major health plans engaged
  - 500 primary care practices- 250 to advanced medical home, over 1 million potential lives- 2 year project will measure outcomes
- Vermont – Blueprint for Health- Gov. Douglas
  - Includes Medicaid and the State Employees in addition to commercial lives
- MN- Health Home Legislation- includes state employees, Medicaid, and commercial lives
- Pennsylvania- Chronic Care PC-MH Model- Gov. Rendell
  - SE Penn- phase one of six- 33 practices ~160 providers- May 2008
- New Hampshire-Statewide to include state employees and Medicaid
- Others- OK, Colorado, RI, Mass., MI, TX, Medicare pilots, etc.

*46 States have pilots or plans for pilots in 2009*

# Patient Centered Medical Homes

## Overview of Activity

- 27 Multi-stakeholder Pilots in 20 States
- New Medicare- Advanced Primary Care Demo Announced
- 44 States and the District of Columbia have passed over 330 Laws and/or Have PCMH Activity



# MEDICARE-MEDICAID “ADVANCED PRIMARY CARE DEMONSTRATION” INITIATIVE

- September 16, 2009 announced by HHS Secretary Sebelius, Director of White House Office of Health Reform Nancy-Ann DeParle, and Vermont Governor Jim Douglas
  - Establishes a demonstration program that will enable Medicare to join Medicaid and private insurers in innovative state-based advanced primary care initiatives
  - Will include mechanisms to assure it generates savings for the Medicare trust funds and the federal government
  - Private insurers work in cooperation with Medicaid to set uniform standards for “Advanced Primary Care (APC) models”
  - Provides incentives for doctors to spend more time with their patients and offer better coordinated higher-quality medical care

# MEDICARE-MEDICAID ADVANCED PRIMARY CARE DEMONSTRATION INITIATIVE

## States Wishing to Participate in the New Demonstration Must:

- Certify they have already established similar cooperative agreements between private payer and their Medicaid program
- Demonstrate a commitment from a majority of their primary care doctors to join the program
- Meet a stringent set of qualifications for doctors who participate
- Integrate public health services to emphasize wellness and prevention strategies

Another program including \$600M announced by HHS to aid Community Health centers towards IT integration and Medical Homes announced in Dec 2009

# Key Recommendations

- State Legislators are key in **leading** State Government (**as a large PAYER**) in delivery system transformation by reimbursing high quality patient-centered care which improves outcomes and **lowers state costs (Medicaid and State Employees)**
  - Examine State policy and agency level action that can enable delivery system reform- ex. MN- “Health Home “ legislation, Penn- Gov. exec. Order
  - Include Health Plans (with their commercially insured lives) and large employers VT/MN/RI are examples
- **Have all providers at the table-** physicians, behavioral health, pharmacists, etc.
  - **A team approach** must include primary care, patient education, behavioral health, comprehensive medication management, and coordination throughout the system with hospitals and specialist
- Include **Patient Advocates** in all phases- **patients are at the center of the Patient-Centered Medical Home transformation**

# It is Your Choice-

Continue to pay a lot \$\$\$\$\$\$\$  
for a SICK CARE SYSTEM



Pay up-front a little \$  
for a HEALTH CARE SYSTEM



OR



# Contact/Resource Information

- To request any additional information on the PCMH or the Patient Centered Primary Care Collaborative please contact Edwina Rogers, Executive Director: [erogers@pcpcc.net](mailto:erogers@pcpcc.net), (202)724-3331  
Visit our website – <http://www.pcpcc.net>
- Commonwealth Fund- slide deck-  
[http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing\\_divide\\_chartpack%20ppt.ppt](http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing_divide_chartpack%20ppt.ppt)
- National Academy for State Health Policy (NASHP)- State Scan of all Medicaid Activity on Medical Homes (June 2009)  
[http://www.nashp.org/\\_catdisp\\_page.cfm?LID=848479CC-1806-43B4-AB0061F96E2426B3](http://www.nashp.org/_catdisp_page.cfm?LID=848479CC-1806-43B4-AB0061F96E2426B3)
- Georgia and Newt Gingrich- PCMH video  
<http://www.youtube.com/watch?v=y6YblwIM2vQ>

# Citations

1. Starfield B, Shi L, and Macinko J., Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood)*. 2001;20:64-78; *ions of Primary Care to Health Systems and Health, Millbank Quarterly*, 2005;83:457-502; Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006
2. A Robert Wood Johnson-funded evaluation of the effectiveness of the Chronic Care Model and the IHI Breakthrough Series Collaborative in improving clinical outcomes and patient satisfaction with care, accessed June 19, 2007 at <http://www.rand.org/health/projects/icice/index.html>; Higashi, Takahiro, Wenger, Neil S., Adams, John L., Fung, Constance, Roland, Martin, McGlynn, Elizabeth A., Reeves, David, Asch, Steven M., Kerr, Eve A., Shekelle, Paul G. Relationship between Number of Medical Conditions and Quality of Care *N Engl J Med* 2007 356: 2496-2504
3. A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007  
[http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing\\_divide\\_chartpack%20ppt.ppt](http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing_divide_chartpack%20ppt.ppt)
4. Dartmouth Atlas of Health Care, Variation among States in the Management of Severe Chronic Illness, 2006 Commonwealth Fund, Chartbook on Medicare, 2006;
5. Spann SJ, for the members of Task Force 6 and The Executive Editorial T: Report on Financing the New Model of Family Medicine. *Ann Fam Med* 2004; 2(suppl\_3):S1-21 PMID 15654084
6. Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other). From presentation by Dobson, Al, Patient-Centered Primary Care Roundtable, March 12, 2007. Accessed June 24, 2007 at [www.patientcenteredprimarycare.org/Meetings/March%202007/March.html](http://www.patientcenteredprimarycare.org/Meetings/March%202007/March.html)