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

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

An Annual Update of the Evidence, 2012-2013
January 2014
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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
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
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
Key Point #1: PCMH evaluations report improvements across a broad range of clinical and financial outcomes
PCMH Peer Reviewed Outcomes

**Cost & Utilization**
- 61% of studies report cost reductions
- 61% report fewer ED visits
- 31% report fewer inpatient visits
- 13% report fewer readmissions

**Care Experience**
- 31% of studies report improved access
- 23% of studies report improved patient satisfaction

**Health Outcomes**
- 31% of studies report increase in preventive services
- 31% report improvements in population health
PCMH Industry Generated Outcomes

- **Cost of Care Utilization**
  - 57% of studies report cost reductions
  - 57% report fewer ED visits
  - 57% report fewer inpatient visits
  - 29% report fewer readmissions

- **Care Experience**
  - 14% of studies report improved access
  - 14% of studies report improved patient satisfaction

- **Health Outcomes**
  - 29% of studies report increase in preventive services
  - 29% report improvements in population health
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
Key Point #2:
PCMHs play a critical role in delivery system reform, including ACOs and the medical neighborhood
PCMH: Foundation to ACOs & the Medical Neighborhood

Community Centers

Public Health

Schools

Employers

Faith-Based Organizations

Community Organizations

Patient-Centered Medical Home

Connected via Health IT

Home Health

Hospital

Diagnostics

Pharmacy

Mental Health

Specialty & Subspecialty

Skilled Nursing Facility

Community Organizations Connected via Health IT
Key Point #3:
Significant payment reforms continue to incorporate the PCMH
Payment Reform Imperative

- Cost Reductions
- Fewer ED Visits
- Fewer Inpatient Admissions
- Fewer Readmissions
- Improvement in Population Health
- Improved Access
- Increase in Preventive Services
- Improvement in Satisfaction
The Year in Review:
Case Study Snapshots
Veterans Health Administration
Patient Aligned Care Team

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

BlueCross BlueShield of Michigan Physician Group Incentive Program

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

Michigan
3 million patients


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UPMC Health Plan Medical Home Pilot

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

CareFirst BlueCross BlueShield Maryland

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/lut/p/c4/04_SB88K8xLlM9m5sPy8xBz9CP0os3hBzN_Q09LYwN_Fw9DA09f18Hj6AgQwNM_2CbEdFANmphzQ1/?WCM_GLOBAL_CONTEXT=/wcmwps/wcm/connect/content PCPCC 2014. All Rights Reserved.
Oregon Health Authority Coordinated Care Organizations (CCOs)

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%


Statewide Medicaid program 600,000 patients
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.