

Health Reform and The Patient-Centered Medical Home

THE
COMMONWEALTH
FUND

Melinda Abrams

The Commonwealth Fund

November 3, 2011

Grantmakers in Health Fall Forum

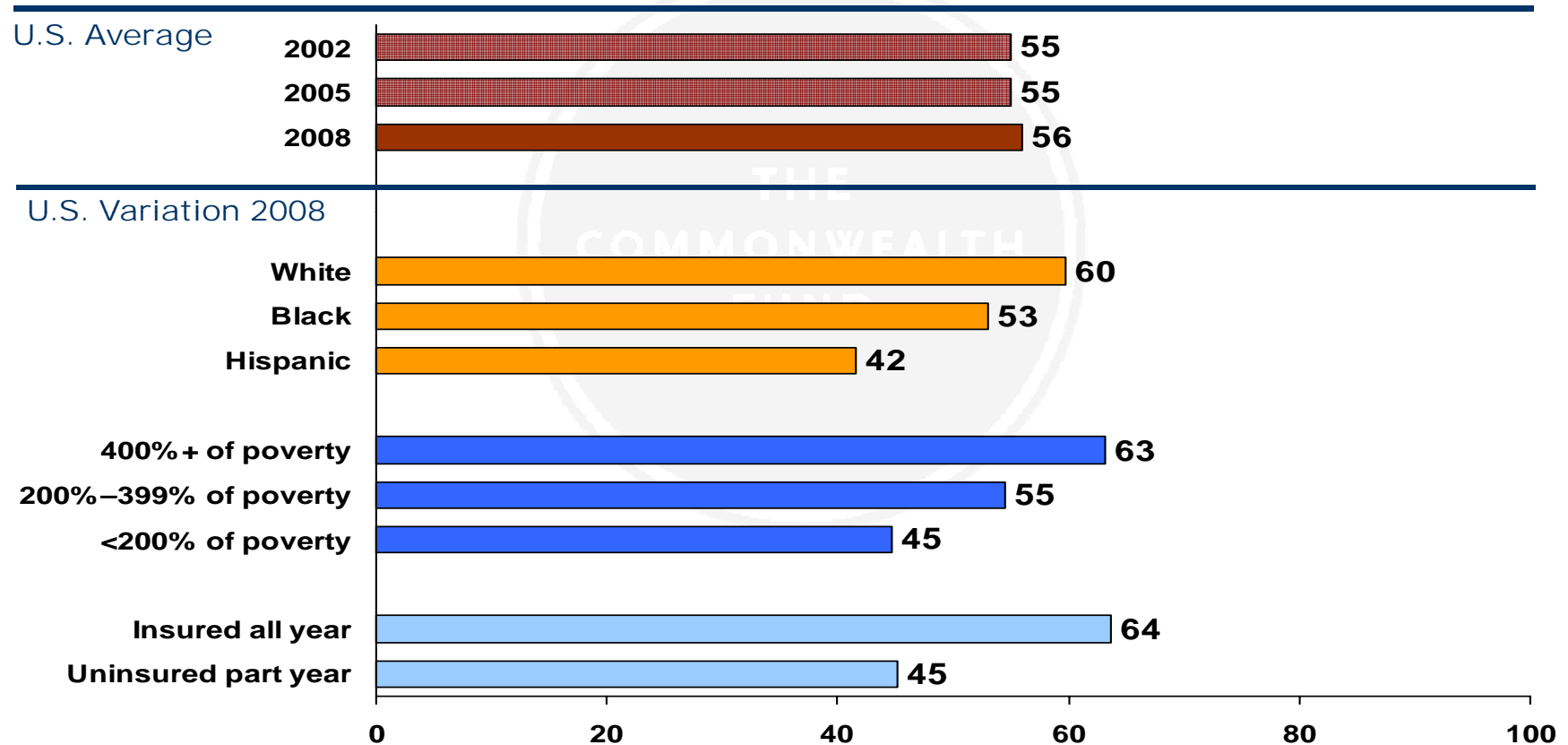
Primary Care Foundation At Risk: Patient Perspective

Patients do not receive timely, efficient care

- Poor access: 71 percent of U.S. adults have difficulty getting timely access to care
- Poor coordination: 47 percent of U.S. adults report failures in care coordination
- Inefficient system: 54 percent of U.S. adults experience wasteful and poorly organized care
- Low confidence: Only 35 percent of U.S. adults are “very confident” they will receive quality and safe care

Disparities Persist: Adult Access to Primary Care Provider Varies by Race/Income

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to and easy to contact by phone during regular office hours.

Data: N. Tilipman, Columbia University analysis of Medical Expenditure Panel Survey.

Why Is Primary Care Important?

Better health outcomes

Lower costs

Greater equity in health

B. Starfield et. al. Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly*, September/October 2005.

Evolution of Medical Home

- Pediatric medical home (1967)
- Definition of primary care (1970s)
- New models of care (Chronic Care Model) (1990s-2000s)
- Joint Principles of Patient-Centered Medical Home (2007)
 - Advanced Primary Care
 - Health Care Home

The Patient-Centered Medical Home: Principles of Four Primary Care Specialty Societies

- **Personal Physician**
- **Physician directed medical practice who manages a care team**
- **Whole person orientation**
- **Coordinated and integrated care**
- **Safe and high-quality care (e.g., evidenced-based medicine, appropriate use of HIT, continuous QI)**
- **Enhanced access to care**
- **Payment that recognizes the added value provided to patients who have a patient-centered medical home**



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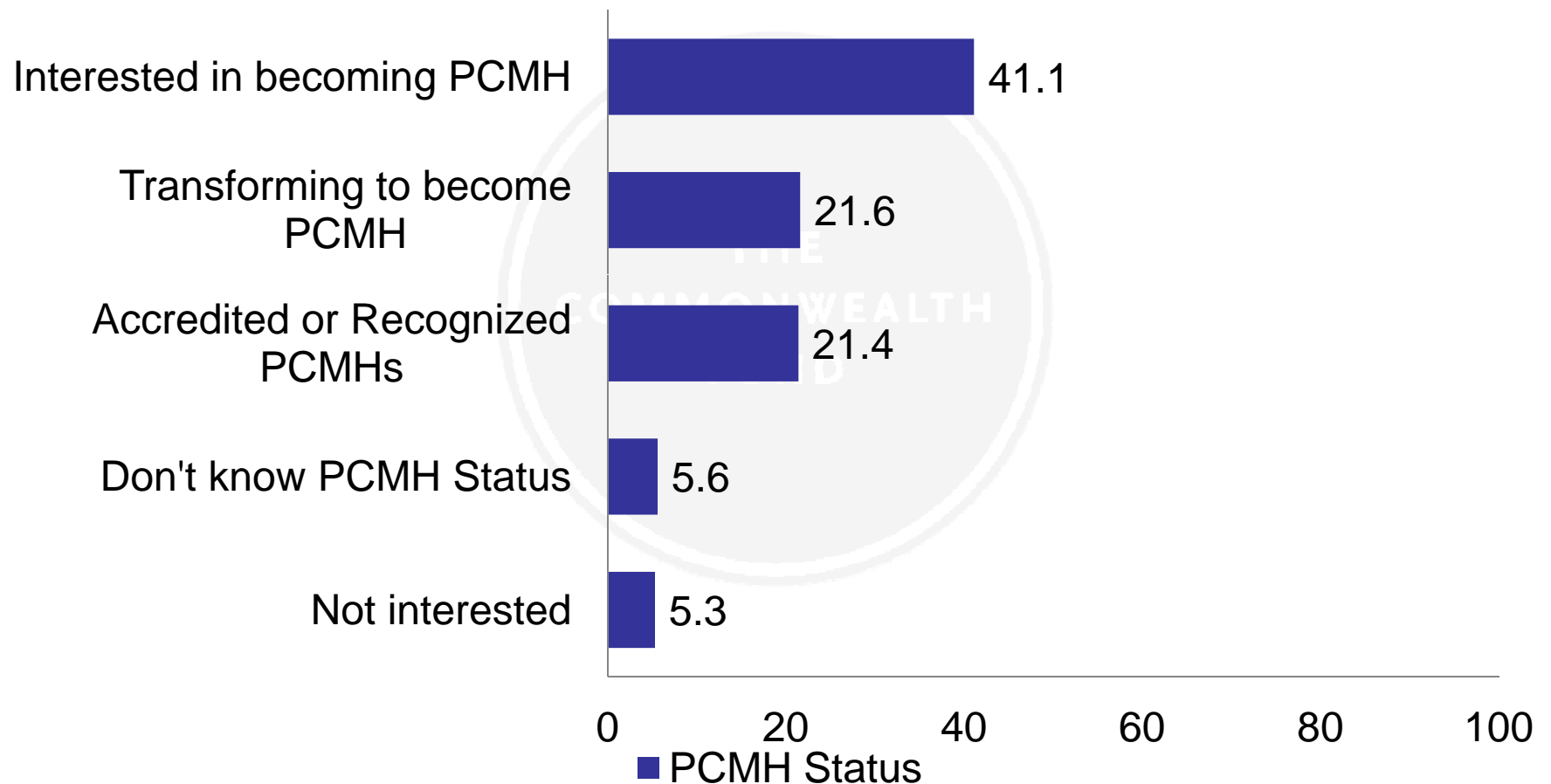
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***** A Systems Approach: Access, Quality and Efficiency**

ACP, AAFP, AAP and AOA. Joint Principals of the Patient-Centered Medical Home, March 2007.

21 Percent of Practices Qualify as PCMH Another 21 Percent in Process

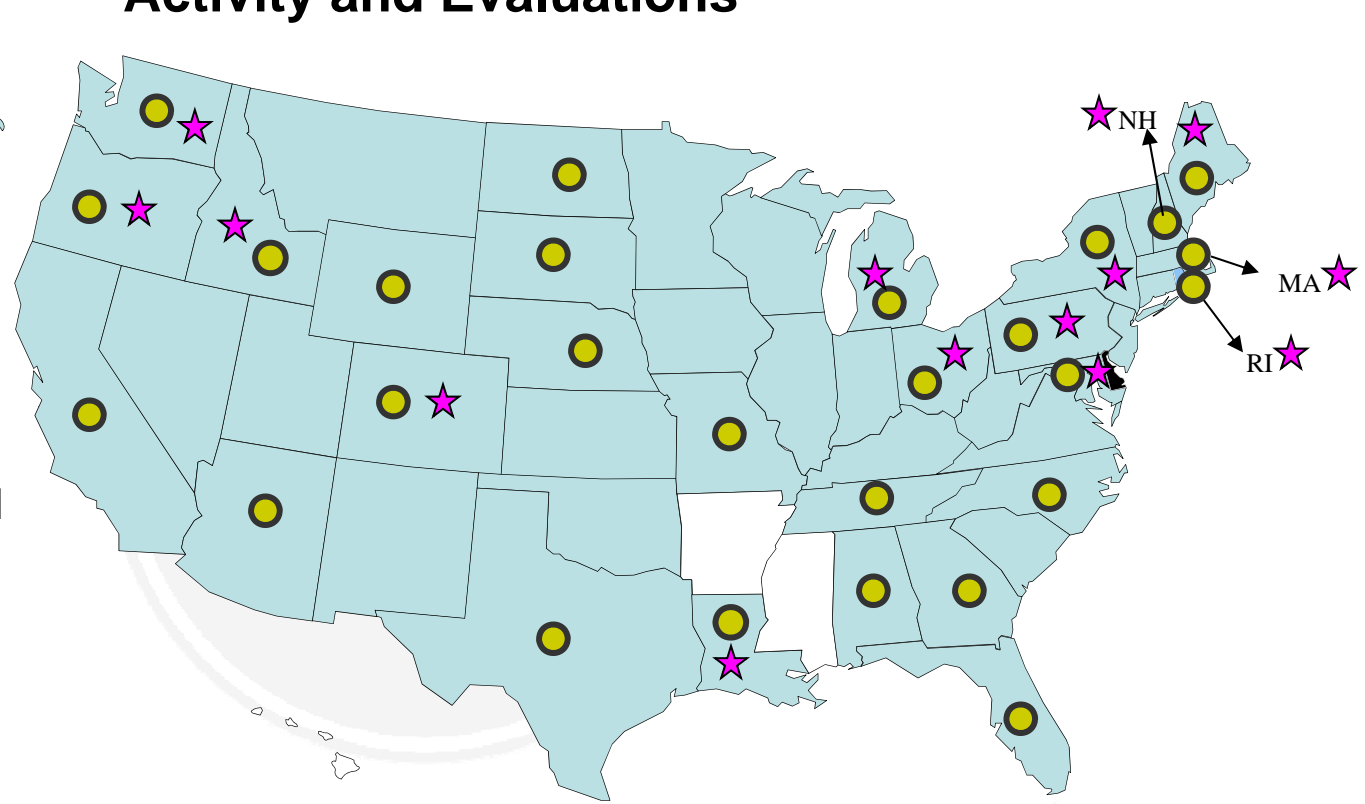


Overview of Medical Home Demonstrations, Multi-Payer Activity and Evaluations

3 Federal Pilots:

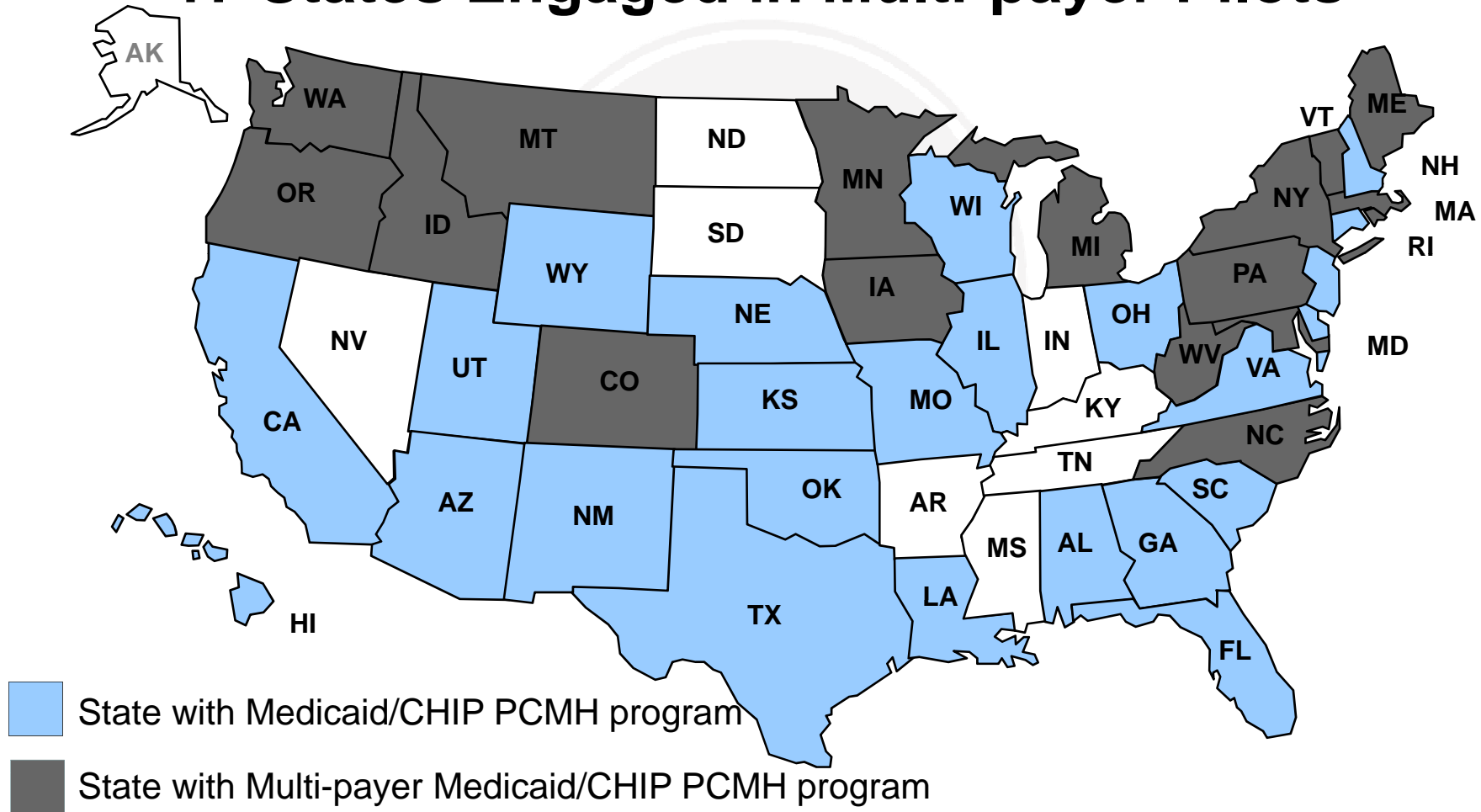
1. **Advanced Primary Care pilot with state Medicaid programs**
2. **Medicare FQHC MH pilot program**
3. **Comprehensive Primary Care initiative**

- ★ Independent evaluations
- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 2 States



41 State Medicaid/CHIP Programs Planning or Launching Medical Home Programs

17 States Engaged in Multi-payer Pilots



Source: National Academy for State Health Policy State Scan, March 2011. <http://www.nashp.org/med-home-map>

States with multi-payer medical home initiatives in place, or with significant resources dedicated to launching a multi-payer project. Significant resources include: formal standing meetings of state officials, executive orders, and legislation.

Medical Home Spread is Substantial

- CMS Innovation Center (3 initiatives)
- Veteran's Affairs
 - PACT initiative
 - 5 million veterans
- TRICARE
 - Redesign of military health plan
 - 2 million beneficiaries
- Bureau of Primary Health Care
 - Strategic priority for FQHCs
 - Supporting PCMH recognition, 500 FQHCs
 - Collaboration with CMS

What We Know So Far

Outcomes of Implementing Patient Centered Medical Home Interventions:

A Review of the Evidence from Prospective Evaluation Studies in the United States

UPDATED NOVEMBER 16, 2010

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A bundant research comparing nations, states and regions within the US, and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient and equitable care than do systems that fail to invest adequately in primary care.^{1,2} However, some policy analysts have questioned

evaluations of patient centered medical home interventions have been released. These include some patient centered medical home initiatives mentioned in our 2009 report which have released updated findings from ongoing assessments, as well as evaluations of new patient centered medical home initiatives not included in last year's report. In total, the patient centered medical home initiatives included in this report involve more than a million patients cared for in thousands of diverse practice settings, involving both private and public payers.

The findings from our updated review are entirely consistent with those of our 2009 report: Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency

Cost and Quality Outcomes: Integrated Delivery Systems

Group Health Cooperative of Puget Sound (Seattle, Washington)

- Cost:
 - 29 percent reduction in ER visits
 - 11 percent reduction in ambulatory sensitive care admissions
 - \$16 per patient per year investment in primary care associated with savings of \$17 per patient per year (not statistically significant)
- Quality:
 - 4 percent more patients achieving target levels on HEDIS quality measures
 - 10 percent of pilot clinic staff reporting high emotional exhaustion at 12 months compared to 30 percent of staff in control clinics

Geisinger Health System (Pennsylvania)

- Cost:
 - 18 percent reduction in all-cause hospital admissions
 - 7 percent total medical cost savings (\$3.7 million) between intervention and control practices (not statistically significant)
- Quality:
 - 22 percent improvement in coronary artery disease care
 - 34.5 percent improvement in diabetes care

Summary of PCMH Evidence with Low-Income Patients

- **Colorado Medicaid and SCHIP**
 - Median annual costs \$215 less for children in PCMH practices due to reductions in ER visits and hospitalizations
 - Median annual costs \$1,129 less for children with chronic diseases in a PCMH practice
- **Community Care of North Carolina**
 - 40 percent decrease in hospitalizations for asthma
 - 16 percent decrease in ER use
 - Total savings to the Medicaid and SCHIP programs: \$535 million
- **Genesee Health Plan (MMC product)**
 - 50 percent decrease in ER visits
 - 15 percent fewer inpatient hospitalizations
 - Total hospital days per 1,000 enrollees cited as 26.6 % lower than competitors
- **Clinic Patients in New Orleans**
 - NoLA clinic patients are less likely to forgo care or report inefficiencies than national average of patients
 - NoLA clinic patients report better access to care than national average
 - Clinic patients with “excellent patient experience” report better access to care, better preventive care and more support to manage chronic conditions

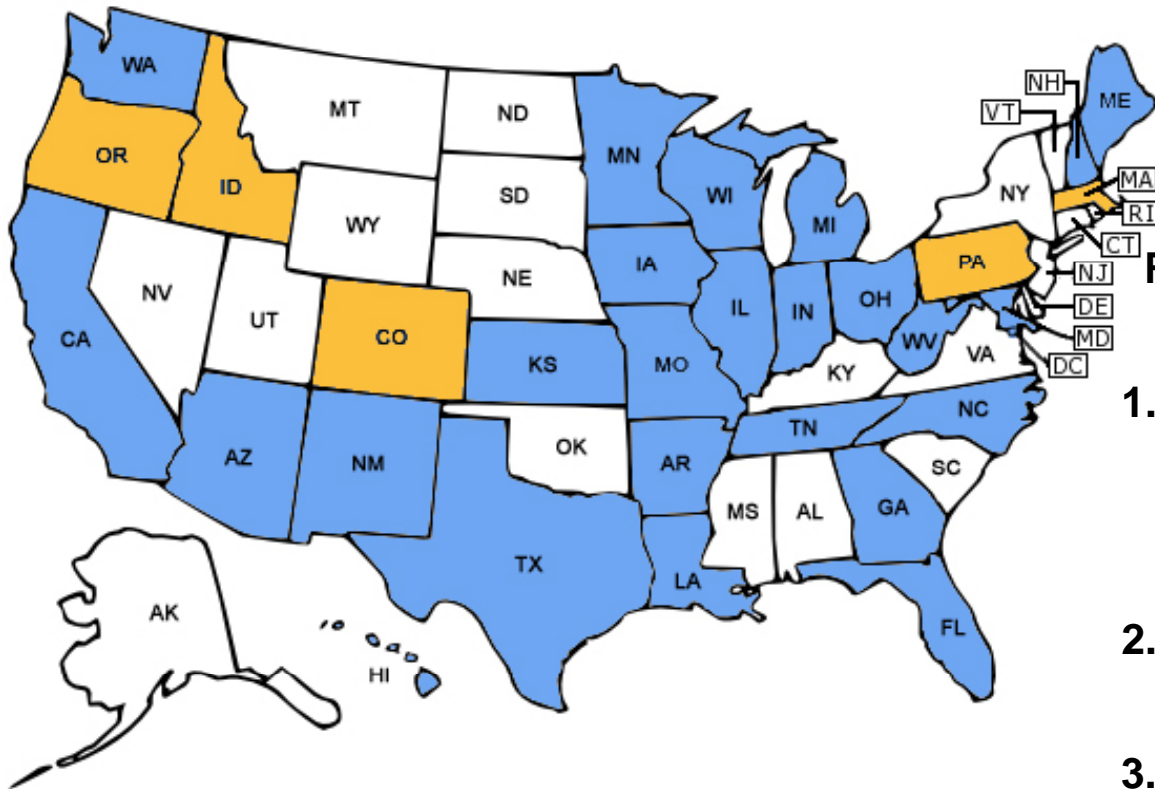
The Commonwealth Fund's Program Focuses on Three Main Areas

1. Testing medical homes in safety net: National demonstration with 65 Community health centers in 5 states
2. Building the evidence base: Supporting 10 evaluations of medical home demonstrations to assess impact on quality, cost/utilization, patient experience, clinician/staff experience, disparities
3. Promoting and facilitating policy change:
 - Research to improve measures
 - Work with state Medicaid and Federal agencies
 - Identify payment options

Safety Net Medical Home Initiative



MacColl Institute at
Group Health Cooperative



Five Regional Coordinating Centers (orange) were selected from 42 applicants (blue) to participate

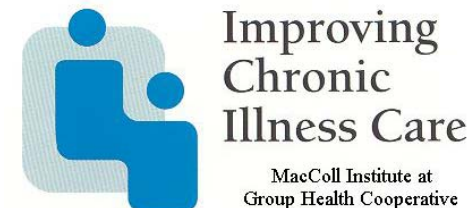
Regional Organizations in Five States Supporting 65 Clinics include:

1. Massachusetts League for Community Health Centers and Executive Office of Health and Human Services
2. Oregon Primary Care Association and Care Oregon
3. Colorado Community Health Network
4. Idaho Primary Care Association
5. Pittsburgh Regional Health Initiative

Qualis Safety Net Medical Home Initiative Identified Eight “Change Concepts”

- Empanelment
- Team-based Continuous Healing Relationships
- Patient-Centered Interactions
- Engaged Leadership
- QI Strategy
- Enhanced Access
- Care Coordination
- Organized, Evidence-based Care

13 “Implementations Guides”
for all 8 Concepts available
free-of-charge at:
www.qhmedicalhome.org



Affordable Care Act: Investing in Primary Care

Medical Homes Critical Part of Strategy

1. Changing Payment and Financial Incentives to Promote Primary Care

- Medicare 10% primary care bonus, 2011-2016
- Medicaid primary care reimbursement increased to Medicare levels, 2013-134
- Incentives for patients to obtain preventive care

2. Testing and Spreading Innovative Ways to Deliver Primary Care

- State option to enhance reimbursement to “health homes” for Medicaid patients with chronic conditions
- Innovation Center: medical home pilots a priority

3. Ensuring Adequate Supply of Primary Care Providers

- Scholarships, loan repayment and training demonstration programs to invest in primary care physicians, mid-level providers and community providers
- \$11 billion for Federally Qualified Health Centers 2011-2015 to serve 15 million more patients by 2015

Ideas for Health Foundations

- Support transformation to medical/health homes
 - Local, regional quality improvement organization
 - Coaching, collaboratives
 - Recognition process (fees)
- Encourage coordination, integration with other providers
 - Behavioral health, public health, specialty care, hospitals
- Help build capacity for ongoing, continuous quality improvement
 - Measurement capacity is critical
- Support assessments/evaluations
- Promote multi-payer collaboration

Thank you!



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