

Patient-Centered Medical Home

Review of the Evidence for Impact on Cost



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Strong Primary Care: infrastructure for high-value healthcare



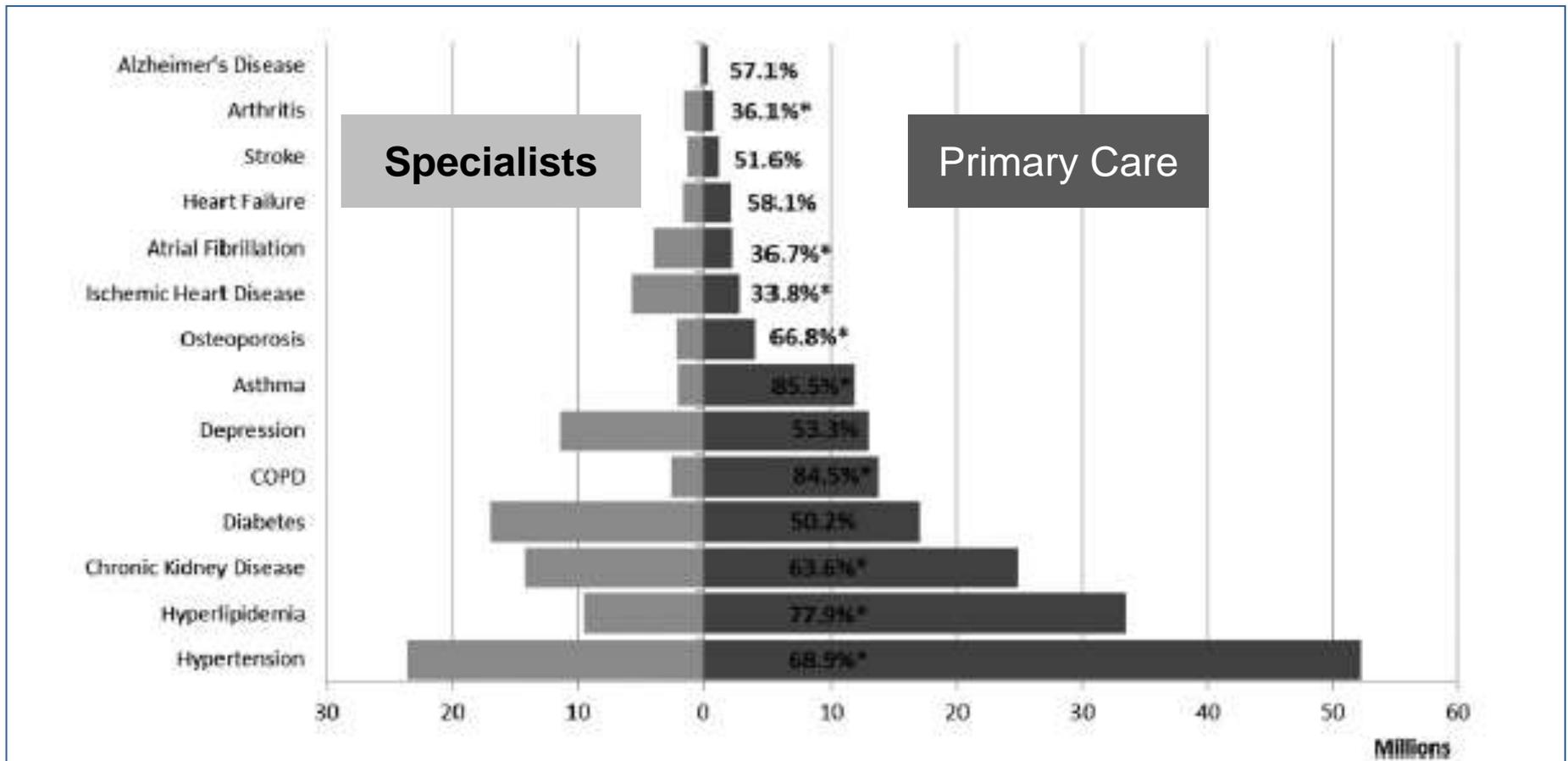
- **First contact care**
- **Early intervention**
- **Identify & Modify Risk**
- **Whole person focus**
- **Longitudinal care**
- **Trusted relationship**

Experienced with:

- **Interactions of Health and Behavior**
- **Drivers of poor health**
- **Interventions at teachable moments**
- **Addressing barriers to health improvement**
- **Balancing competing treatment priorities**
- **Family /Community context**

Outpatient Visits for Chronic Conditions

based on 2008 National Ambulatory Medical Care Survey, Sharma et. al. JABFM 2014



Primary Care provided 69% of chronic condition outpatient visits.
majority of hypertension, asthma, depression, COPD and diabetes visits

Patient Centered Medical Home (PCMH) is “New and Improved” Primary Care

A “best practice” model for the delivery of high-value primary care
and

A primary care practice redesigned with key evidence-based
enhancements that deliver better healthcare value

Also known as:

“medical homes”

“health homes”

“advanced primary care”

“medical care coordination”

“patient-aligned care teams”



“Joint Principles of the Patient Centered Medical Home” 2007

The model endorsed by all primary care professional organizations AAFP, ACP, AAP, AOA

Patient-Centered Medical Home

Evidence-based Enhancements for Primary Care



Patient-Centered
Supports patients in managing
decisions and care plans.

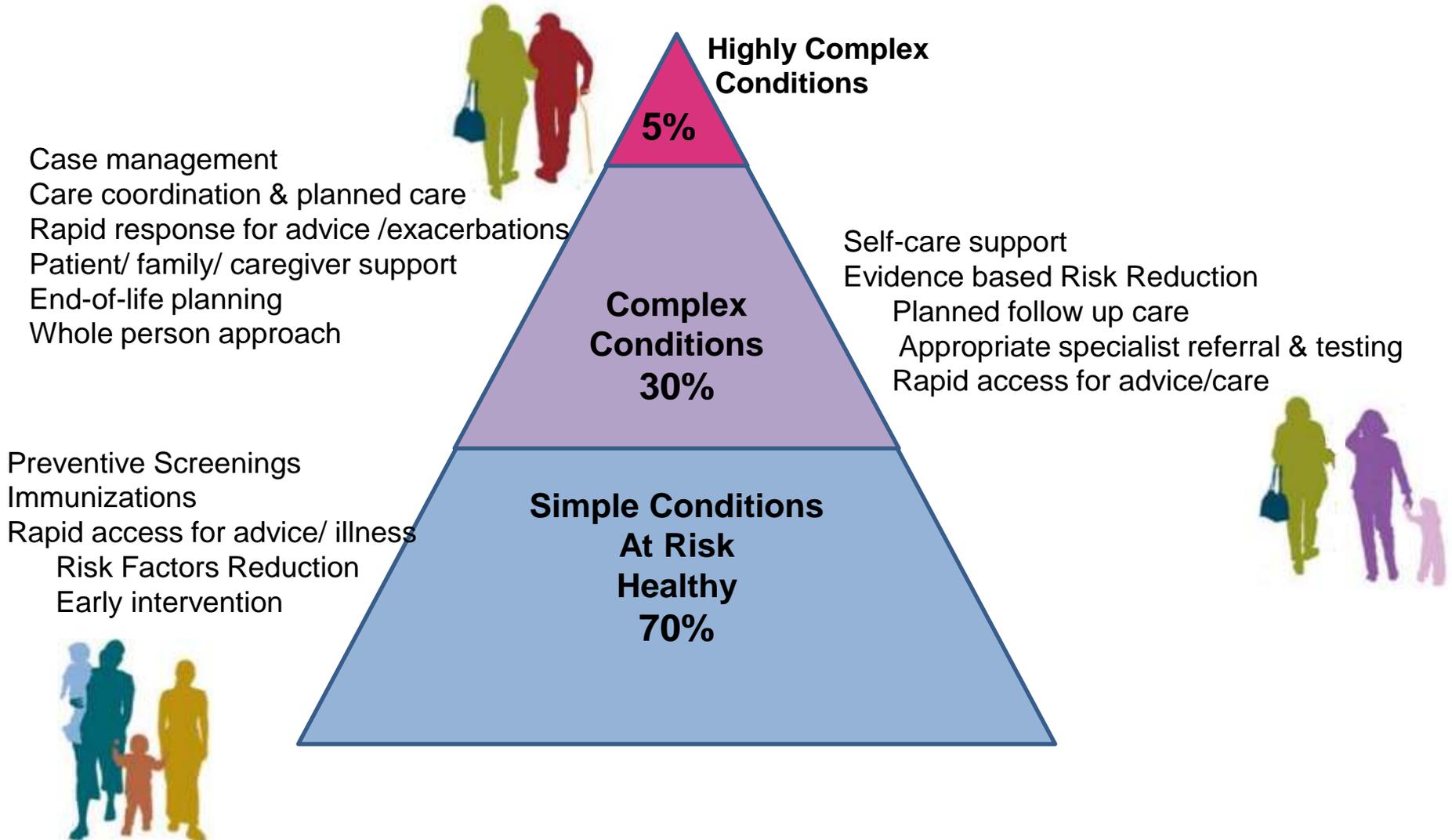
Comprehensive
Whole-person care provided by
TEAM

Coordinated
Care is organized across
the 'medical
neighborhood'

**Committed to
quality and safety**
Maximizes use of health IT,
decision support and other tools

Accessible
Care is delivered with short
waiting times, 24/7 access
and extended in-person
hours.

Enhanced Primary Care impact on the continuum of health



Evaluations of PCMH Impact: 2013-14

Patient Centered Primary Care Collaborative Annual Review, 2015

Aggregated outcomes from the 28 peer-reviewed studies, state government program evaluations, and industry reports:

 **17**
found
improvements
in cost

 **24**
found
improvements
in utilization

 **11**
found
improvements
in quality

 **10**
found
improvements
in access

 **8**
found
improvements
in satisfaction

CHALLENGES

- Broad array of enhancements**
- Difficult to measure degree of implementation**
- Limited payment reform**
- Lack of aggregated data**
- Results take TIME**

Community Care North Carolina 2007-2011

Filmore et al, Population Health Management Sept 2013

Intervention:

750,000 Medicaid non-dual eligible
“Medical Homes” with enhanced access,
quality improvement and
care coordination
\$2.50 PMPM CM fee plus FFS
Regional networks/ Community-based
case management supported with \$3 PMPM

Results

Significant Cost Savings ($p < 0.005$)

- 2008 \$52 PMPM
- 2009 \$80 PMPM
- 2010 \$72 PMPM
- 2011 \$120 PMPM

Reduced rate of hospitalization (despite higher risk) while rate *increased* for non-enrolled ($p < 0.001$)

14 PEER-REVIEWED STUDIES

 10 reported on cost, 6 found improvements

 13 reported on utilization, 12 found improvements

 3 reported on quality, 2 found improvements

 4 reported on access, 4 found improvements

 4 reported on satisfaction, 4 found improvements

Highmark PCMH Program

Highmark Press Release, October 2014

7 INDUSTRY REPORTS



4 reported cost savings



6 reported reductions in utilization



3 reported improvements in population health/preventive services



1 reported improvement in access



1 reported improvement in patient or clinician satisfaction

Intervention:

1 million members in PCMH program

Practice facilitators

Shared data

Bonus tied to quality and cost

Fee boost for NCQA PCMH

Results

Lower utilization for PCMH vs. other members::

-16% ED adult care

-14% ED Medicare Advantage

-13% ED Pediatrics

-2% Medicare Readmission rate

-12% adult inpatient surgery

-25% Medicare medical inpatient care

Oklahoma SoonerCare Choice, 2009-2013

Oklahoma Health Authority, Sept 2014

7 STATE GOVERNMENT EVALUATIONS



7 reported cost savings



6 reported reductions in utilization



6 reported improvements in population health/preventive services



5 reported improvements in access



3 reported improvements in patient or clinician satisfaction

Intervention:

PCMH providers chose one of three tiers

Case management fees and quality bonuses

Central population health / disease management

2010 added community networks

2013 practice-based health coaching

Results

Annual growth of PMPM 1.5% vs national rate of 3 %

Total ROI 562%

-12% in ED Visits

Significant reduction in hospitalizations for COPD, CHF, and pneumonia

Improved preventive screenings, appropriate treatment

High patient (70%) and provider satisfaction (91%)



WVU Family Medicine Experience: 2012 to 2015

Interventions:

NCQA standards guided redesign

Improved **Access**

Team-based care

Multidisciplinary team for **Care Transitions**

Nurse Case Managers for **High-Risk Care Coordination**

Entire staff participated in **Culture of Improvement**



Results--Cost/ Utilization

Highmark 2012-2013 –lower overall cost by \$66 PMPM for 1082 patients

Geisinger Health Plan 2012-2014

-43% Medical –Surgical Admissions

-52% Readmissions

-14% ED utilization

Quality

Diabetes A1c testing and control from 25th percentile to 75th percentile

Improved 7 and 14 day post-hospital follow-up by 20%

Improved Highmark PCMH quality from Level 2 to Level 3 (41 of 50 possible points)



PCMH Approach:

right care, right place, right time

Barry Smith

35 year old restaurant worker

Diabetes

Foot neuropathy

Previous toe amputation

Poor glucose control A1c 12%

2011-2012

Recurrent foot infections

three ED Visits with hospitalization

A second amputation



Fall 2012

PCMH *Practice-based* Nurse Case Management

- **Frequent insulin adjustment with PCP**
- **Monitored wound status till amputation**
- **Coordinated PCP and specialist visits**
- **Increased self-care ability**

**32 case manager
interactions over
3 years**

2013

Hypertensive urgency treated successfully as outpatient

2013

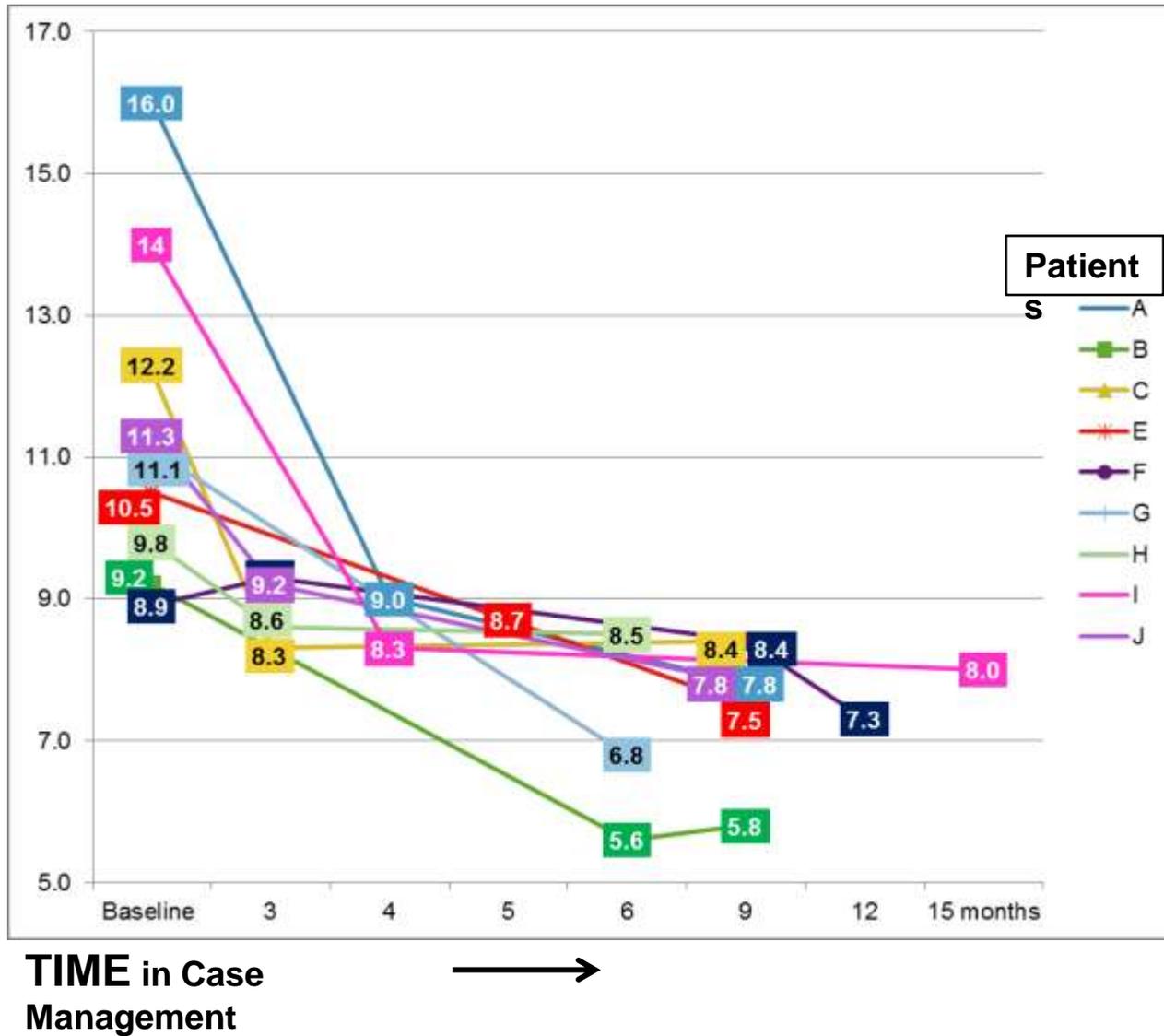
Foot blister treated successfully as outpatient

**No ED visits or hospitalizations for next 18 months
Maintained glucose control, full time work
and active lifestyle!**

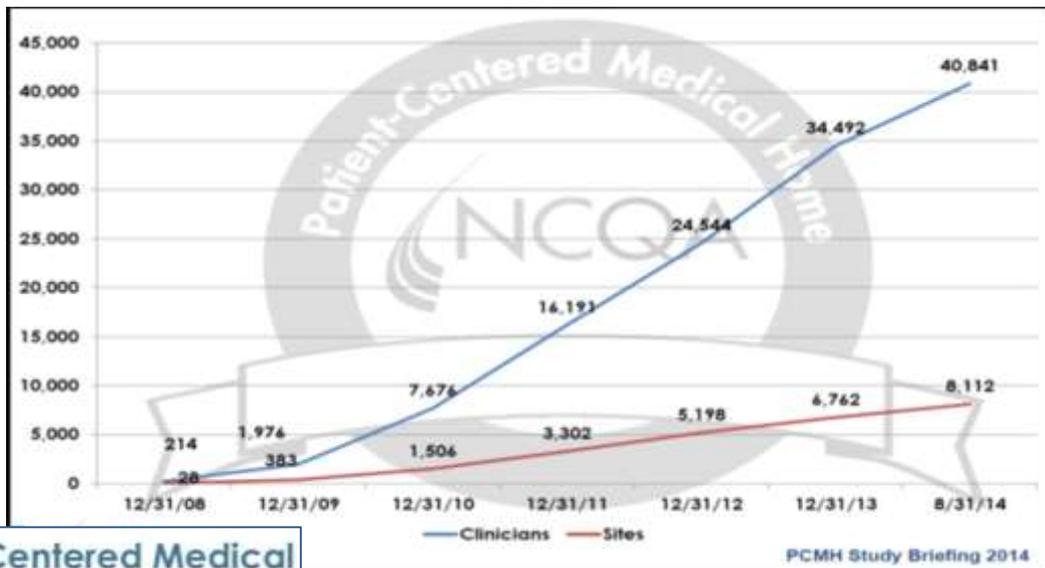


Case Series: A1C Levels decrease with Case Management

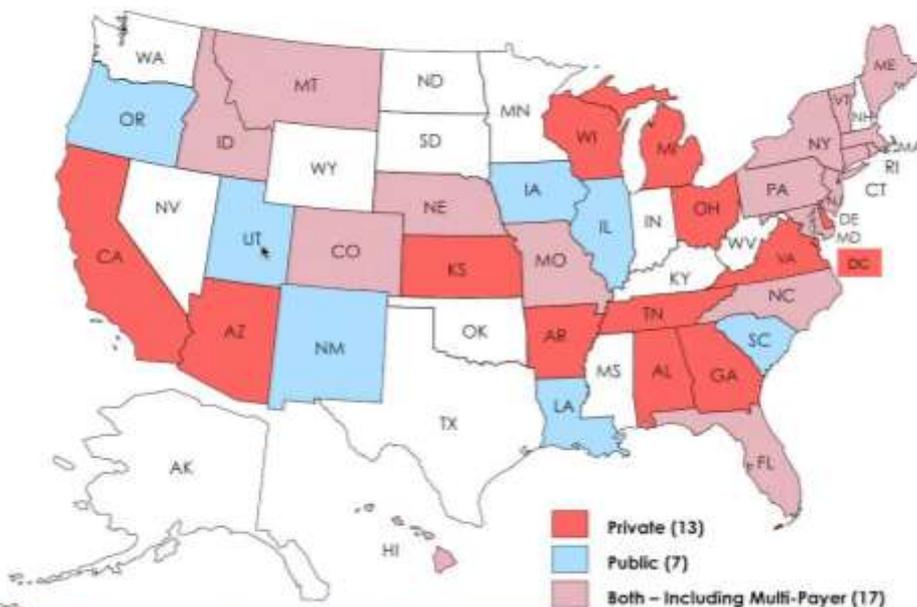
A1C



NCQA PCMH



37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition



Wide acceptance

**40,000 providers
 Over 8000 practices**

**37 States with PCMH
 initiatives (public or
 private)**

NOT the only standard

NCQA PCMH in West Virginia

Total of 44 recognized practices

28 Level 3

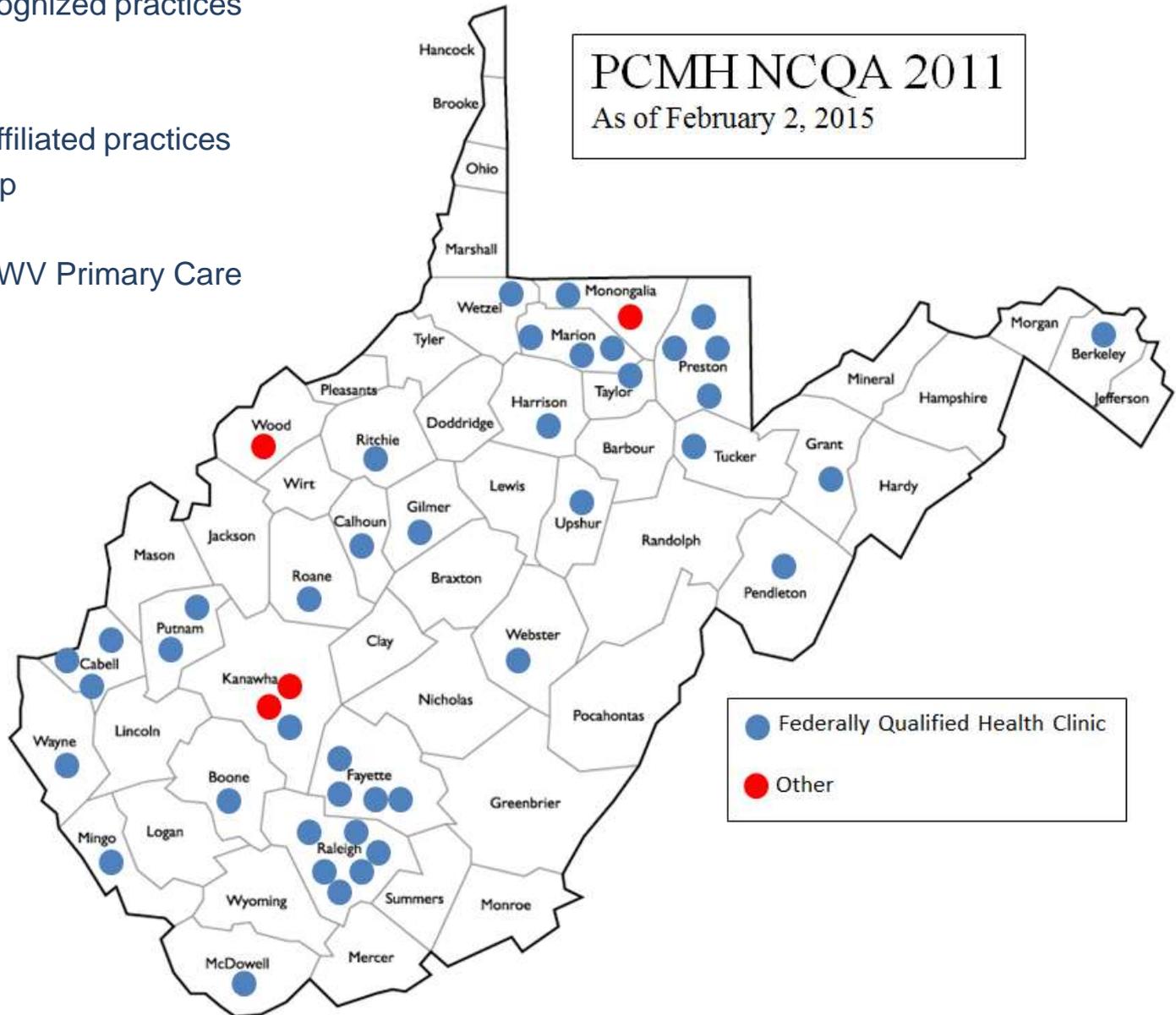
40 FQHCs

3 academic-affiliated practices

2 private group

208 providers

About 12% of WV Primary Care





Discussion ?

