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Medical Homes:
How Coordinated Health Care Delivery Can Help Maximize Revenue Growth

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How Coordinated Health Care Delivery Can Help Maximize Revenue Growth

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Deloitte.

The medical home: Disruptive innovation for a new primary care model

Paul Keckley, Ph.D.
Deloitte Center for Health Solutions

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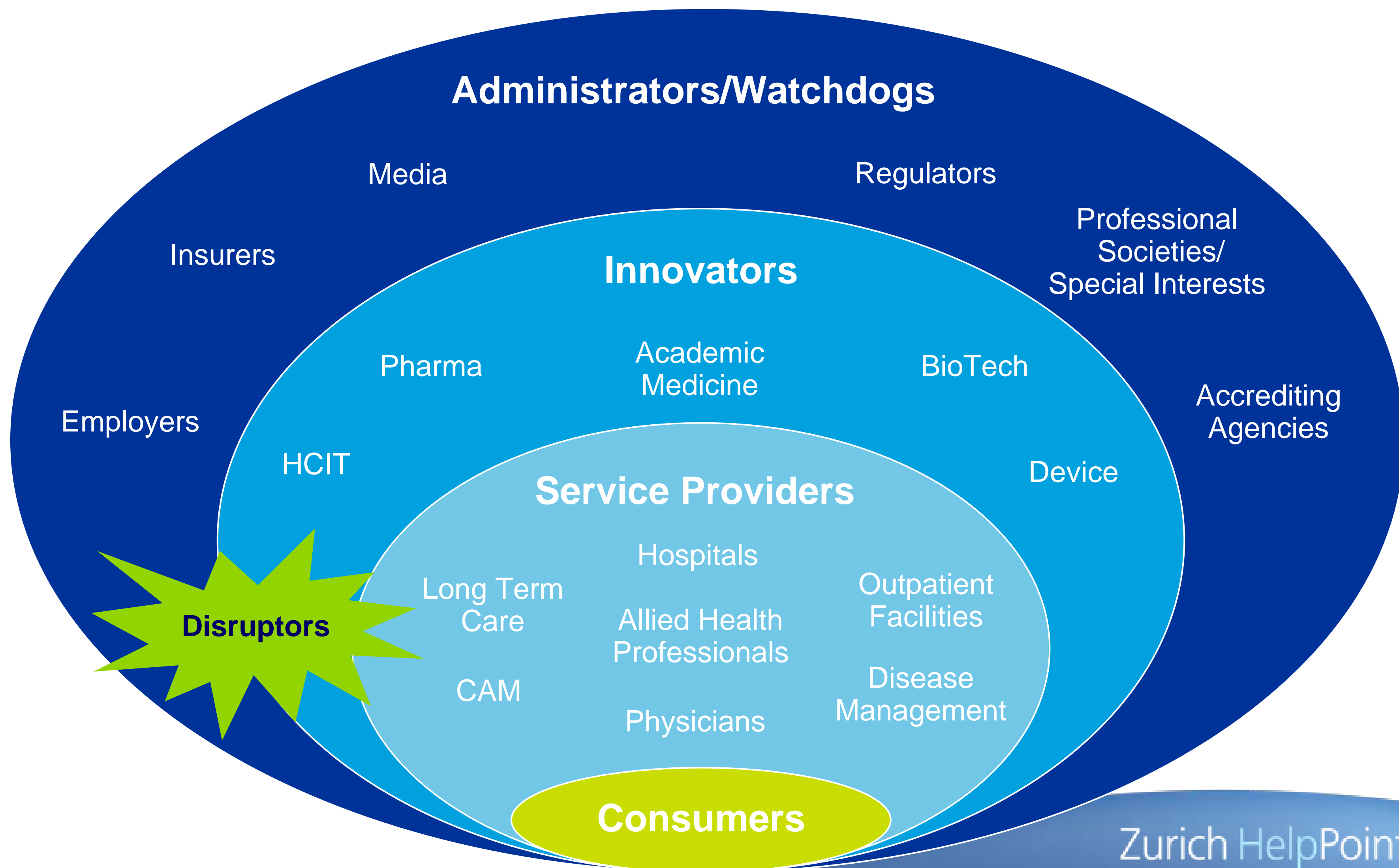
There's no place like home

Deloitte.

- The Patient-Centered Medical Home model is one in which individuals use primary care practices as the basis for accessible, continuous, comprehensive, and integrated care
- Goal of a medical home is to provide a patient with a broad spectrum of care
  - Preventive and Curative
  - Over a period of time
  - Coordinate all of the care the patient receives

The U.S. health system today: fragmented, expensive, complicated

Deloitte.



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Current landscape

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Physicians have difficulty delivering care due to complications from chronic co-morbidities

- Reimbursement is less
- Lack of necessary tools and incentives

Employers see profits that could be applied to enhance global competitiveness being consumed by health care costs

- Employee benefit plans have little success in reducing spiraling costs driven by chronic conditions

Regulators and policymakers realize that there is a disconnect between incentives, the management of chronic conditions, and overall health care system effectiveness

Consumers with chronic conditions acknowledge limited success in their own self care

Number of pilot medical home programs expected in 2009 and 2010

Medical Home programs are located throughout the United States and are being set up with major academic medical center, large health insurers, and major corporations. Some examples are as follows:

Group	Timeframe	Purpose
UnitedHealth Group and IBM in Arizona	3 years	Reduce amount of pay physicians receive for providing services and focus on higher compensation for increasing levels of quality care
Johns Hopkins Bloomberg School of Public Health	Beginning in 2010	$1.7 million grant to assist practices in the CMS Medical Home Demonstration Project. Launched in eight states. Focus on coordinating care among elderly patients living with chronic medical conditions
Cigna and Dartmouth-Hitchcock	First evaluation after 12 months	Enhance coordination and quality of care for 19,000 patients. No change in choice of primary care physicians. PCPs will be paid for medical services they provide with additional amount for enhanced services, such as care management

SWEDISH

The Swedish approach to medical home

Jay Fathi
M.D., *Medical Director* Swedish Medical Center

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Swedish Health Services Seattle

- $1.5 billion per year revenue
- 3 acute care hospitals, just acquired management contract w/ public district community hospital, and building additional new suburban hospital
- >50% revenue outpatient/ambulatory services
- 14 primary care clinics

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Swedish Community Health

SWEDISH

- Opened in March 2009 at Swedish Ballard
- Incorporate most features of the patient-centered medical home
- 2 physician FTEs, 1 mid-level provider, 2 RN care coordinators, 6 family medicine residents
- 30 minute standard visit
- Recruiting tool for primary care post graduate education

Payment system

- Reimbursement reform is key to overhaul of system; 'primary care capitation'
- Clinic receives a 'flat fee' per patient per month, based on age/health status, etc.
- Premera Blue Cross, Molina (state Medicaid plan) payers
- Anyone can pay $45/month to enroll
- Subsidized services for uninsured patients

Aligning incentives

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Pay clinics for prevention/quality, not volume

- Financial incentives based on care, not visits
- Additional payments if mutually agreed upon thresholds are met for basic national screening tests, DM/HTN management, immunizations, etc.
- ACCESS-bonus for decreasing ED visits, inpatient hospitalizations

Moving forward

- Medical Home Division created
- EMR, AND registry, are critical
- Care management/chronic disease management key (nursing/health coach role)
- Patient and staff satisfaction very high; finances and outcomes to be determined

SWEDISH

Jay Fathi

Dr. Jay Fathi is the founding medical director of primary care and community health for Swedish Health Services in Seattle. A board certified family physician, Jay serves as a liaison between Swedish Medical Center and its primary care physicians, and he has been a leader in the development of Swedish Community Health Clinic, an innovative medical home pilot project.

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Geisinger medical home

Janet Tomcavage
RN, MSN, VP of Health Services,
Geisinger Health Plan

Geisinger Health System

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An Integrated Health Service Organization

Provider facilities

- Children's hospital
- 2 Acute care hospitals
- Heart and cancer centers
- Women's center
- Drug & alcohol Tx center
- 4 ambulatory surgery centers
- 30K Admissions & 800 in-pt beds

Physician practice group

- 700 physicians
- 40 comm. practice sites
- 1.5 million visits
- 220 Interns & residents

Managed care companies

- Over 245,000 members
- Diversified products – commercial, Medicare, TPA, CHIP
- 80 contracted hospitals
- 1000 contracted physicians

Proven Health Navigator^{sm} objectives

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- Improve patient experience, health status and efficiency
- Transform primary care from transaction to value focus
- Act as Value Vehicle (Integrator) to improve quality and efficiency across the spectrum of care

Health Navigator significantly expanded since 2007

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	Sites	Gold members	Commercial members	PGP members
Phase 1	3	3,100	800	
Phase 2	10	7,300	6,000	10,200
Phase 3	12	4,600	5,900	6,200
Phase 4	12	4,300	12,300	4,700
Total	32 GHS and 5 non GHS	19,300	25,000	21,100

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Geisinger's PHN model has five core components

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Component	Elements
Patient-centered primary care	• Patient and family engagement & education • Enhanced access and scope of services • Team-based care • Chronic disease and preventive care optimized with HIT
Integrated population management	• Population segmentation and risk stratification • Preventive care • GHP employed in-office case management • Disease management
Value care systems	• Micro-delivery referral systems • 360°care systems – SNF, ED, hospitals, HH, etc.
Quality outcomes	• Patient satisfaction • HEDIS and bundled chronic disease metrics • Preventive services metrics
Value-based reimbursement	• Fee-for-service with P4P payments for quality outcomes • Physician and practice transformation stipends • Value-based incentive payments • Payments distributed on Quality Performance

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Embedded case managers are key to success

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- Embedded Case Manager (per 700-800 Medicare pts)
  - High risk patient case load 15 - 20% (125 - 150 pts)
  - Beyond disease education
- Personal patient link
  - Comprehensive care review – medical, social support
  - Transitions follow up (acute/SNF discharges, ER visits)
  - Direct line access – questions, exacerbation protocols
  - Family support contact
- Recognized site team member
  - Regular follow ups high risk patients
  - Facilitate access – PCP, specialist, ancillary
  - Facilitate special arrangements (emergency home care, hospice care)
- Linked to remote tele-monitoring for specific populations

Lessons learned along the way

GEISINGER

- It is possible to improve patients' health while reducing costs
- Requires change in primary care delivery model; the change is not easy
  - Needs active, engaged providers
  - Needs active, empowered team
- Transitions of care create specific gaps and opportunities
- Critical to have case manager embedded in primary care site
- Patients with very complex conditions need very close follow-up through every system of care
- Primary care represents just one component of the health care delivery reform needed

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Janet Tomcavage

Janet Tomcavage is vice president of health services for Geisinger Health Plan. Geisinger has received national attention for its medical home program, called ProvenHealth Navigator, because of its success in improving quality and patient and provider satisfaction while decreasing medical costs.

Janet is responsible for the administrative oversight of health services including quality improvement, appeals and grievances, clinical reporting, and population management. Recently, she has led the development and implementation of Geisinger's ProvenHealth Navigator program. She has also worked for over 20 years in the specialty of diabetes management.

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The impact of medical home on patient outcomes and costs

Jove Graham
Ph.D., Geisinger Center for Health Research

Analyzing outcomes: Points to consider

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- Defining the start time
  - “Up & running” vs. “smooth & stable”
- “Selecting” (defining) a control cohort
  - Patients probably not randomly selected
  - Sites probably not randomly selected
  - Propensity scores, other matching
  - Simple “before vs. after” not necessarily a real effect
- Process vs. Patient Outcomes
  - Both important
  - If process improves, but patients do not…?
  - If patient outcomes improve, but process did not…?

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Process outcomes

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	2007 to 2008	p-value
Preventive care bundle	+9.2%	<0.001
Diabetes bundle	+3.3%	<0.001
Diabetes: HbA1c <7	+5.6%	<0.001
CAD bundle	+3.9%	<0.001

- Clinics measure the % of patients receiving all services (e.g., screenings, immunizations, gold standard treatments) in a 'bundle'
- % of patients in PHN clinics receiving each bundle did improve from 2007 to 2008

Patient outcomes: Analytic approach

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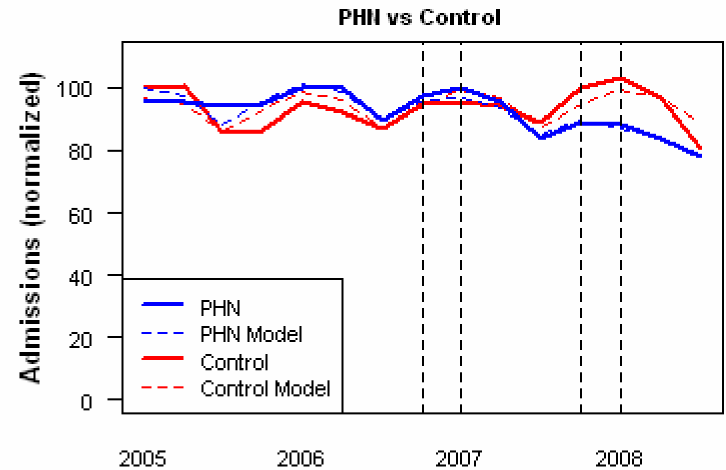
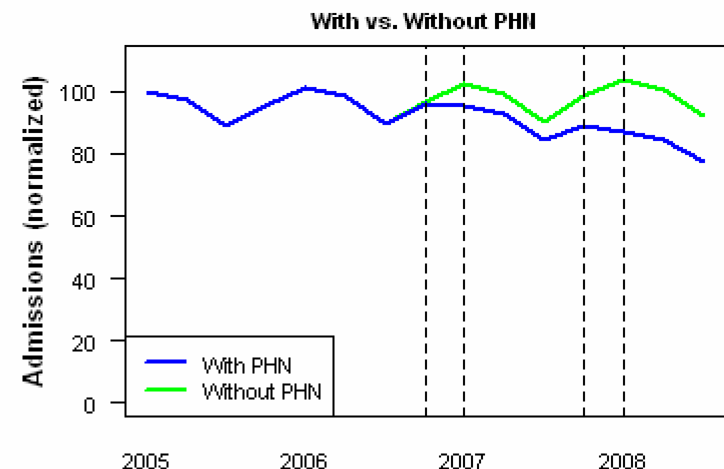
- Population of Medicare Advantage members over 4-year period (before & after PHN)
- Fit mixed models to all data to adjust for time trends (year), seasonal trends (month), risk score (HCC)
- Use models to predict incremental effect of PHN (i.e., what outcomes *would have been* if PHN clinics had not implemented PHN)
- Calculate expected differences, with ±95% CI's





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Performance and financial outcomes

Impact on admissions & readmissions

- Admissions: 18% reduction (-30 to -5% CI)
- Readmissions (30-day): 36% reduction (-55% to -3%)

Impact on total costs

- Total allowed expenses (plan payment + co-payment), excluding prescription pharmacy costs
- Costs: 7% reduction (-18 to +5% CI)
- Suggests an improvement, but not yet statistically significant

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Jove Graham

Jove is a comparative effectiveness researcher for the Geisinger Center for Health Research, where he works with the clinical and surgical departments within the health system to study and compare patient outcomes after various surgical or pharmaceutical treatments, with the goal of helping doctors choose the most effective options for their patients. He is heavily involved in the statistical modeling and outcomes research analysis for Geisinger's ProvenHealth Navigator.

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Resurrection Health Care®
For All of You, All of Your Life

Launching a medical home pilot

David DiLoreto
M.D., CMO, Resurrection Health Care

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Resurrection Health Care

- Chicago based faith based health care system
- Nine acute care facilities, 12,000 employees, 3,000 physicians
- Seven post acute care facilities, four assisted living facilities and home health
- Historically small independent PCP practices
- Strategic initiative underway to develop a system-wide employed group
- Using the conceptual framework of the patient centered medical home for aligning the new clinical practices

Patient centered primary care home

Resurrection Health Care
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- Creates a distinct identity and market differentiator for Resurrection
- Is complimentary to the desired attributes of the new physician group practice model
- Consistent with clinical integration model
- Enhances managed care contracting efforts

NCQA
Patient centered medical home

Resurrection Health Care
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- Program reflects input from multiple specialty societies
- Provides a systematic framework
- Health plan familiarity with organization

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Funding

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- EMR- RHC capital
- Patient registry and analytics funded through clinical integration pilot, PQRI bonuses
- Health plan interest in demonstration projects and EMR protocol adoption

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Resurrection Health Care®
For All of You, All of Your Life

David DiLoreto

Dr. David DiLoreto, executive vice president and chief medical officer of Resurrection Health Care, a 9-hospital regional health system in Chicago. As part of Resurrection's senior leadership team, David directs the clinical integration of nine acute-care facilities, as well as post-acute care in 12 nursing homes and four assisted living centers. A board-certified ophthalmologist and oculoplastic surgeon, he also manages physician networks and directs quality improvement efforts.

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Context: Consumers are embracing innovations

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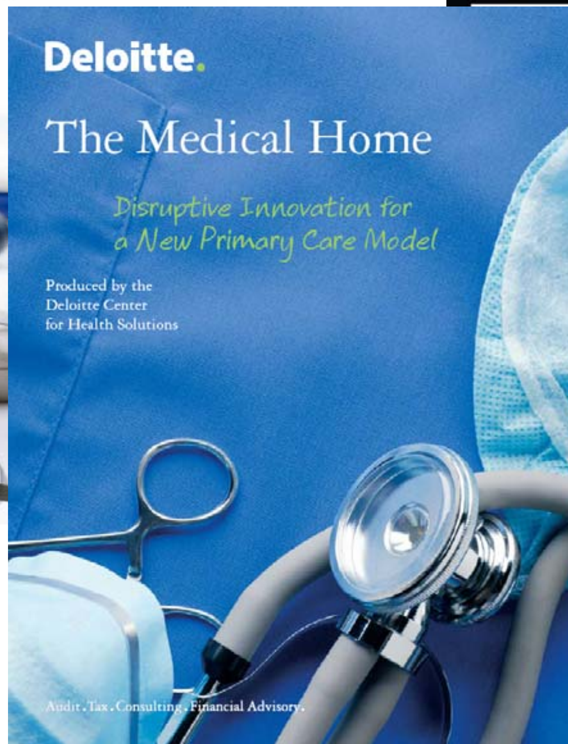

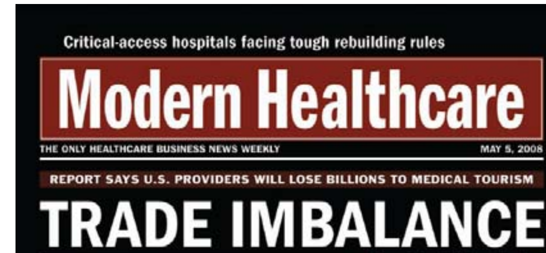

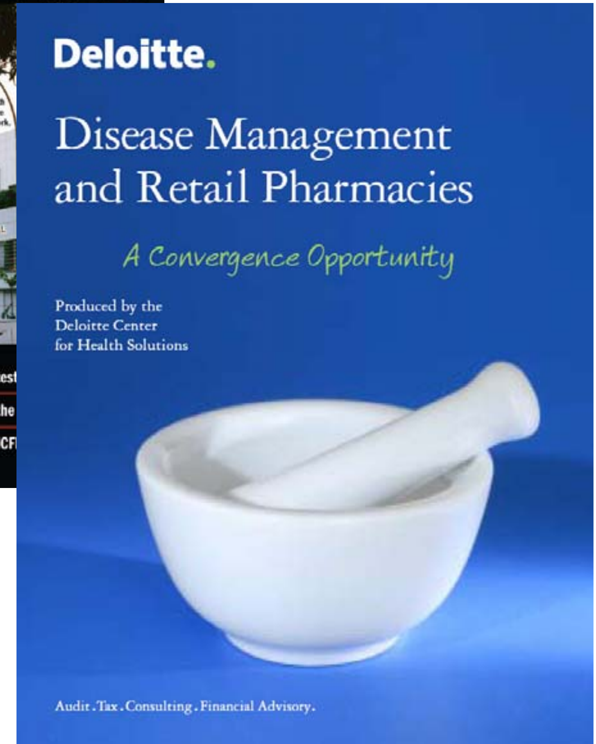

Model promising but not without problems

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Two trends are helping to build momentum around the medical home model:

- Growing shortage of primary care clinicians due to adverse practice conditions
- Increasing prevalence of chronic diseases among the U.S. population

Medical home model is promising because it has the potential to reduce overall costs, however…

- Lack of incentives around chronic care coordination and preventive health services
- Divergent interests of specialists and acute care practitioners

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Implications of the medical home for key stakeholders

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Primary care physicians	Hospital with substantial PCP referral network	Commercial health plan	Public payers
Level of Risk – High	Level of Risk – Moderate	Level of Risk – Moderate to High	Level of Risk – Moderate to High
• Requires a one-time investment of ~$100K , ongoing expenses would increase to ~$150K or more • Requires revamping practice operations and streamlining process • Requires partnering with strategic partner to operationalize the model	• If medical home model is structured within a hospital's existing PCP network, hospital would risk losing revenue from 10% fewer admissions and 20% fewer ED visits • Might risk relationships with community-based specialists (loss of volume) • Hospitals can leverage their investment in IT to facilitate transformation from hospital to care management organization	• Could be positive strategy in a community where a health plan wishes to provide a value-added service to a group of large employers that hold substantial liability for retiree health costs • Perception that physicians distrust health plans – may be necessary for sponsoring health plan to make the up-front investment in the medical home and provide bonus structure tied to cost savings and population-based outcomes	• Similar situation to commercial health plans • Shift from current reactive (acute) reimbursement approach to one of prevention and are coordination • The current Medicare Medical Home Demonstration encourages broad participation in pilot to help determine where the medical home has the best opportunities for success

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Paul Keckley

Paul Keckley is the executive director of the Deloitte Center for Health Solutions, an independent research organization focused on trend analysis and issues of the US health system. Paul is a health economist who brings 30 years of healthcare policy experience to our discussion, including at one time serving as executive director of the Vanderbilt Center for Evidence-based Medicine, where he oversaw studies focusing on the applications of evidence-based medicine to pay-for-performance programs.

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