Direct Pay + FFS Visit Revenue

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Three Imperatives of Health Care Reform

- Cost Reduction
- Quality Improvement
- Service Improvement

Two System Changes

- Macrosystem – Local Health System – Accountable Care Organization (ACO)
- Microsystem – Office Practice – Patient Centered Medical Home (PCMH)

What People Want and Need

- Relationship Centered Care
- Getting their health care needs met efficiently
- Getting a high level of expertise in their care

What is Optimal Medical Care?

- Patients receive all the time they need and want for care with great service
- Patients receive the best care
- Physicians and staff enjoy their work and sustain high level professional satisfaction
- Medical errors are minimized
- Physicians are supported by a team and care for the right number of patients

PCMH Short Definition

Care Coordination By A Team Outside of Visits

Systems of Care are Forming in Each Community Rather than Independent Practice

Systems that are Value Driven (Quality Care at Affordable Costs)

Three Transformative Concepts Happening Today

- Care becomes continuous rather than episodic
- Care becomes strategically proactive rather than reactive
- Patients become activated for self-management

We are seeing the end of episodic health care driven by 20th century technologies – the telephone and the automobile

Information age health care is continuously accessible using new communication technologies

The Time Problem – Current Primary Care

- Time Needed for Chronic Illness Care
- Time Needed for Preventive Care
- Time Needed for Acute Care
- Total face to face time for 2500 patients

- 10.6 hours a day for 2500 patients
- 7.4 hours a day
- 4.6 hours a day
- 22.6 hours/day

Ann Fam Med 2005;3:209

Am J Pub Health 2003;93:635

The Ticking Clock in the Doctor's Office

Patients leave the office with an average of 3 unanswered questions

- *New York Times,* February 6, 2007

58 y/o female with obesity and diabetes comes in with symptoms of fatigue, insomnia and back pain. She has a 15 minute appointment

HEDIS diabetes measures for this patient:

- Percent with an annual retinal exam
- Percent with one of more glycohemoglobin tests
- Percent of those having glycohemoglobin tests showing a level of <8.5 percent (goal <7.0)
- Percent with an annual screening test for microalbuminuria
- Percent with two or more blood pressure checks per year
- Percent of those with one or more blood pressure checks having a systolic BP <135 (goal <<130/80)
- Percent with an annual lipid panel
- Percent of those with an annual lipid panel showing an LDL level <130 mg/dL (goal << 100)

Case con't

What about getting:

- Flu vaccine
- Pneumonia vaccine
- Dental visit
- Cardiac screening tests?
- Lab monitoring for side effects of meds
- Annual monofilament foot exam

Case con’t

Cancer Screening needs:

- Colon- needs colonoscopy (or 3 other types of screening)
- Cervical- needs pap if last <1-3 years prior
- Breast- needs annual exam and mammogram

Osteoporosis screening and prevention

Depression Screening and Management

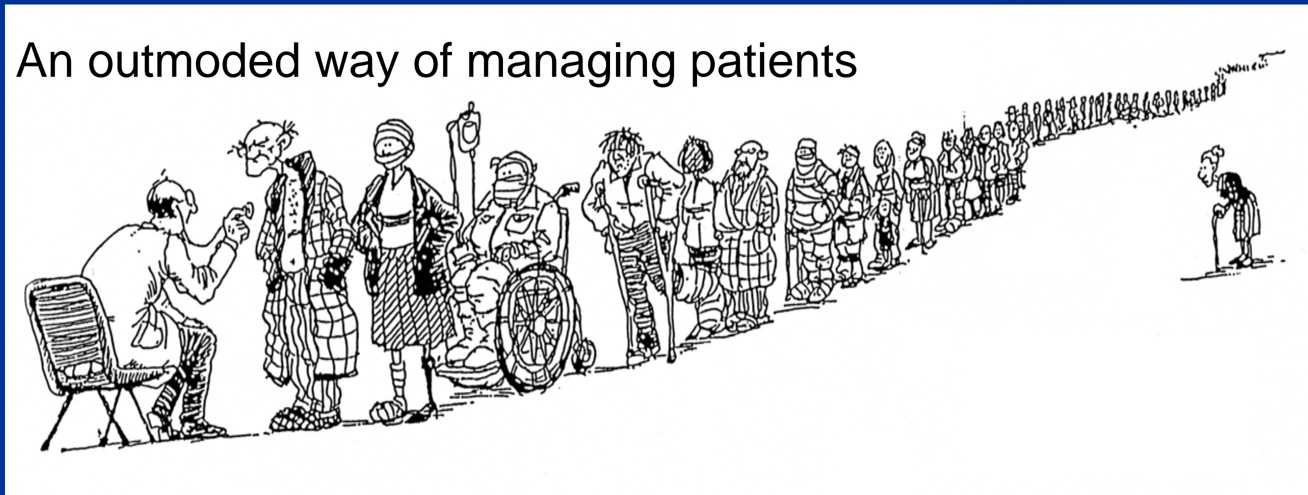
Case con’t

Other general health issues:

- Adult tetanus and pertussis vaccines
- Weight management
- Advance directives
- Culturally-sensitive care
- Patient education for self management
- Tobacco screen
- Alcohol screen
- Domestic violence screen
- What About her fatigue, insomnia and back pain?

Care Does Not Equal Visits

- Optimal care is based on deep, trustful relationships between practice and patients
- A great relationship demands that we go far beyond visits in delivering care to patients



Patient

Preventive Care Needs

Health Problems/Comorbidities

Biopsychosocial Dimensions

Family Context

15-minute Visit

Family Physician

Knowledge and Experience

Relationship with Patient

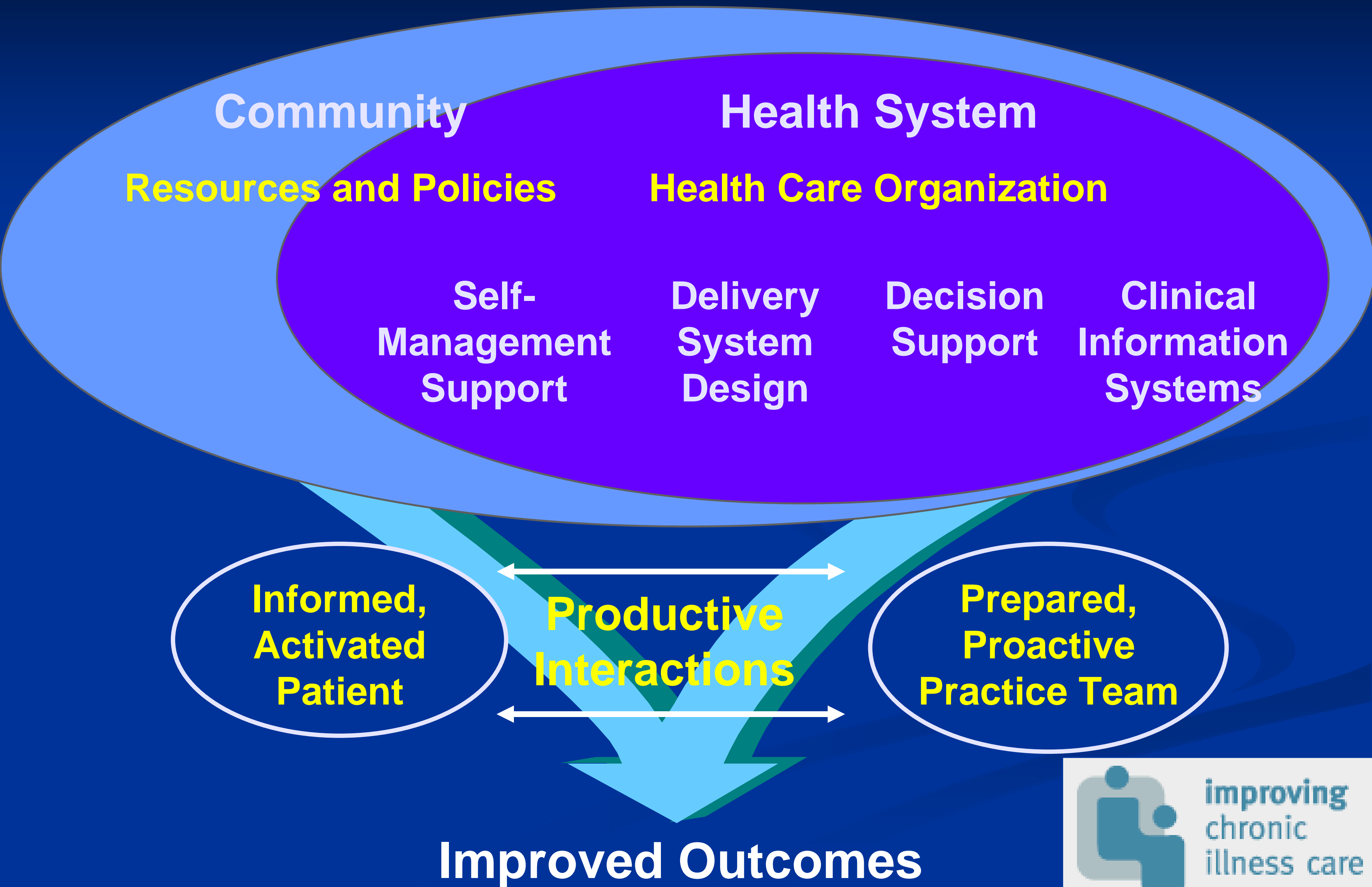
Coordination of Comprehensive Care

Resources

Figure 1. The Bottleneck of Brief Episodic Visits

The Care Model

http://www.improvingchroniccare.org



Organized Team Model

- Larger panel size per physician
- Everyone works to the limit of their license, dividing the services among the team
- Medical Home care coordination payment may be as low as $4 pmpm to pay for care coordinator
- Physician work schedule focuses on more complex patient

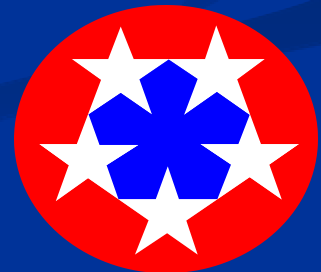
Relationship Centered Model

- Smaller panel size per physician
- Longer visits and fewer patients seen daily
- Activated medical assistant, often an LVN or RN, serves as a patient care coordinator in co-practice with the physician
- Medical Home care coordination payment larger, $30-50 pmpm, often paid by the patient as a "membership" to the physician (resembles concierge practice with online communication rather than cell phone)

HIT Functions for Ideal Medical Care

- Patient Registry – needed for proactive care and quality measurement
- eRx – needed for avoiding medication errors
- EHR – needed for organizing and accessing patient data
- Clinical Decision Support – needed for smart practice and avoiding medical errors
- Patient Portal – needed for continuous access for communication and care

Are You a Member of Eisenhower 365?



Eisenhower Primary Care 365 Origins

- 1998 - Idealized Design of Clinical Office Practice (IHI collaborative and annual conferences)
- 2001 - Crossing the Quality Chasm (IOM Report) Care is based on a continuous health relationship (and not on visits)
- 2001 – Launch of Greenfield Health Practice in Portland, OR by Chuck Kilo and others
- 2007 – Patient Centered Medical Home movement begins

What is an Optimal Primary Care Panel Size?

- 2000 to 3000 numbers are historic and not based on any strategic analysis – origins from a time when people when to physicians only when they were sick - may work for organized team model
- Greenfield Health panel size 1000
- EPC 365 panel size 900 with more seniors
- Concierge medicine with cell phone access – 200 to 600

PCMH Hybrid Financial Model

- Payment for communication and care coordination by a team outside of visits
- EPC 365 - $395 age up to 55, $595 age 56 and over annually for individuals, $40 per person discount couples and household family, no fee for children 18 and under if parents join
- Regular billing for office visits
- 60% of income comes from the fee.
- Physician incomes of 225-250k with 10-12 visits/day (overhead cap of 60%)
- Physician income potential over 300k with 900 patients

PCMH Direct Care Model

- Bundled payment of $75 or more per month for all primary care services including office visits
- Reduced overhead from not billing insurance companies allows for reduced fees
- Works well for a private practice
- Does not work for integrated delivery systems that are hospital owned

The Major Redesign Elements of Ideal Medical Care

- Care becomes continuous rather than episodic based only on visits
- Care becomes proactive rather than reactive
- Patients become activated for greater self-management

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