# MEDICAL HOME SUMMIT: CLOSING REMARKS

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# PAINTING THE VISION: NEED FOR NEW PARADIGM

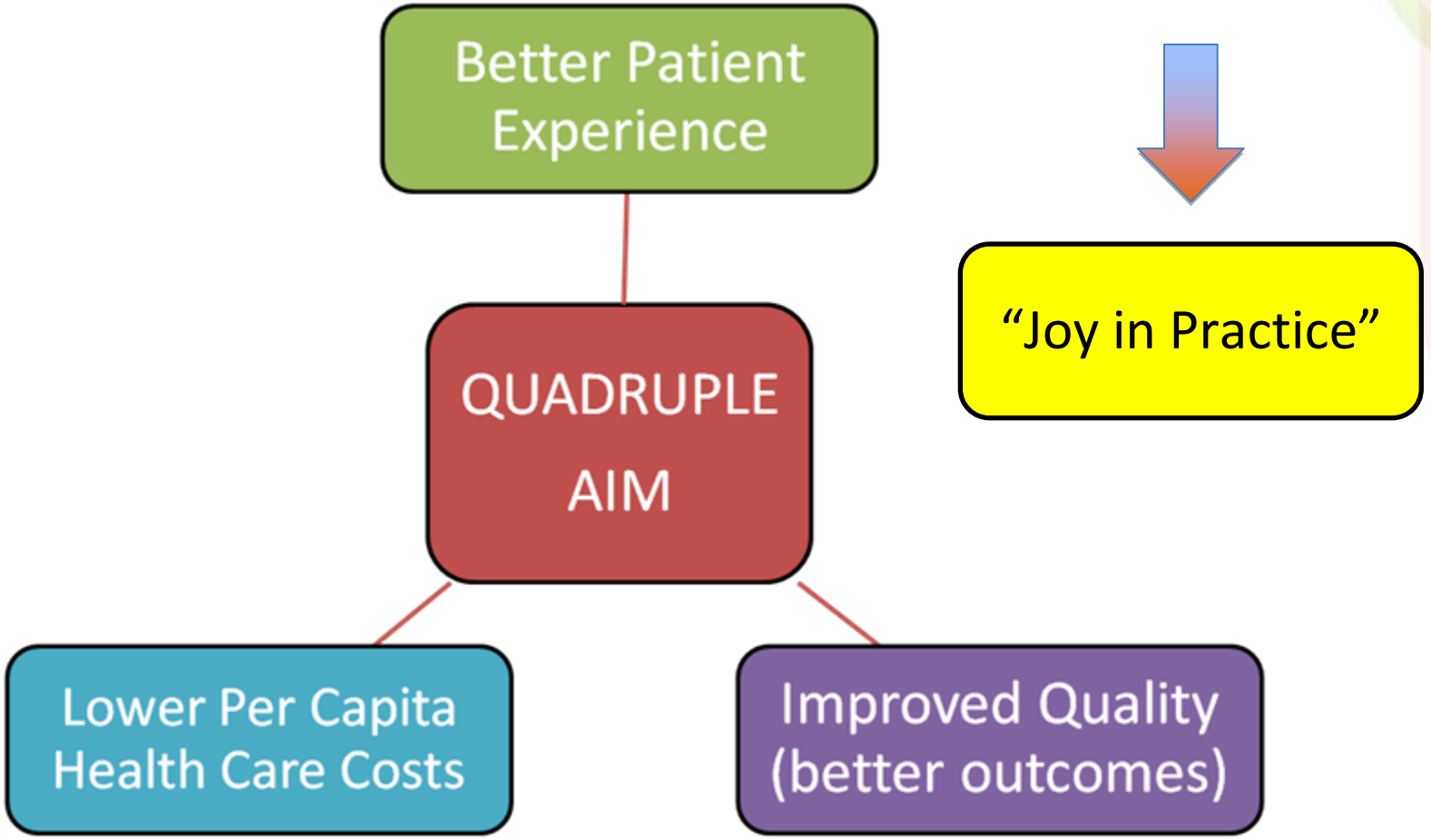
## Current Health Care System

- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial
- "Everyone For Themselves"

## Future with PCMH Implementation

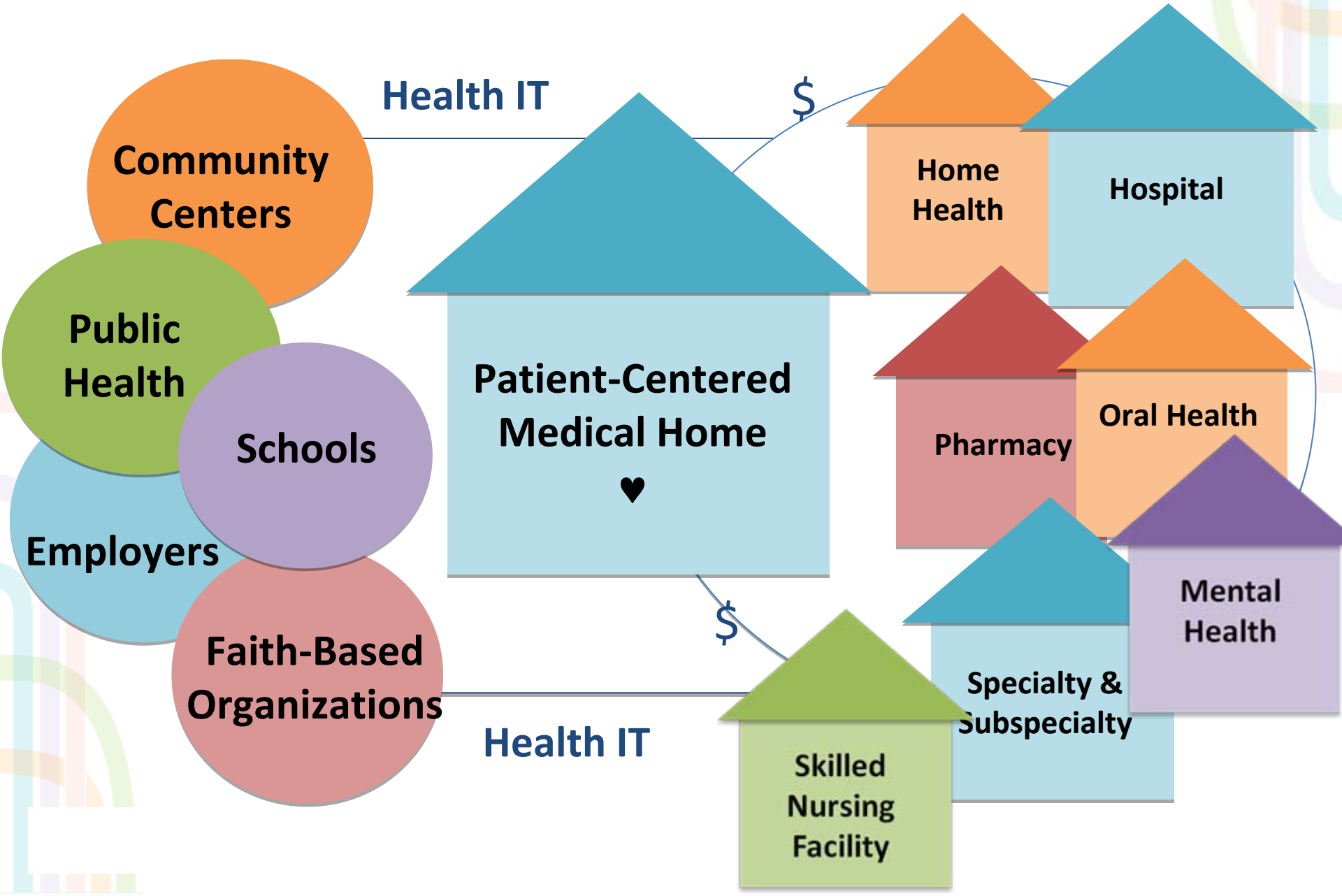
- Managing Populations
- Collaborative Care
- Primary Care Driven
- Integrated eHealth Records
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative
- Joint Contracting

# NATIONAL IMPERATIVE: "~~TRIPLE~~ AIM"
# "QUADRUPLE AIM"



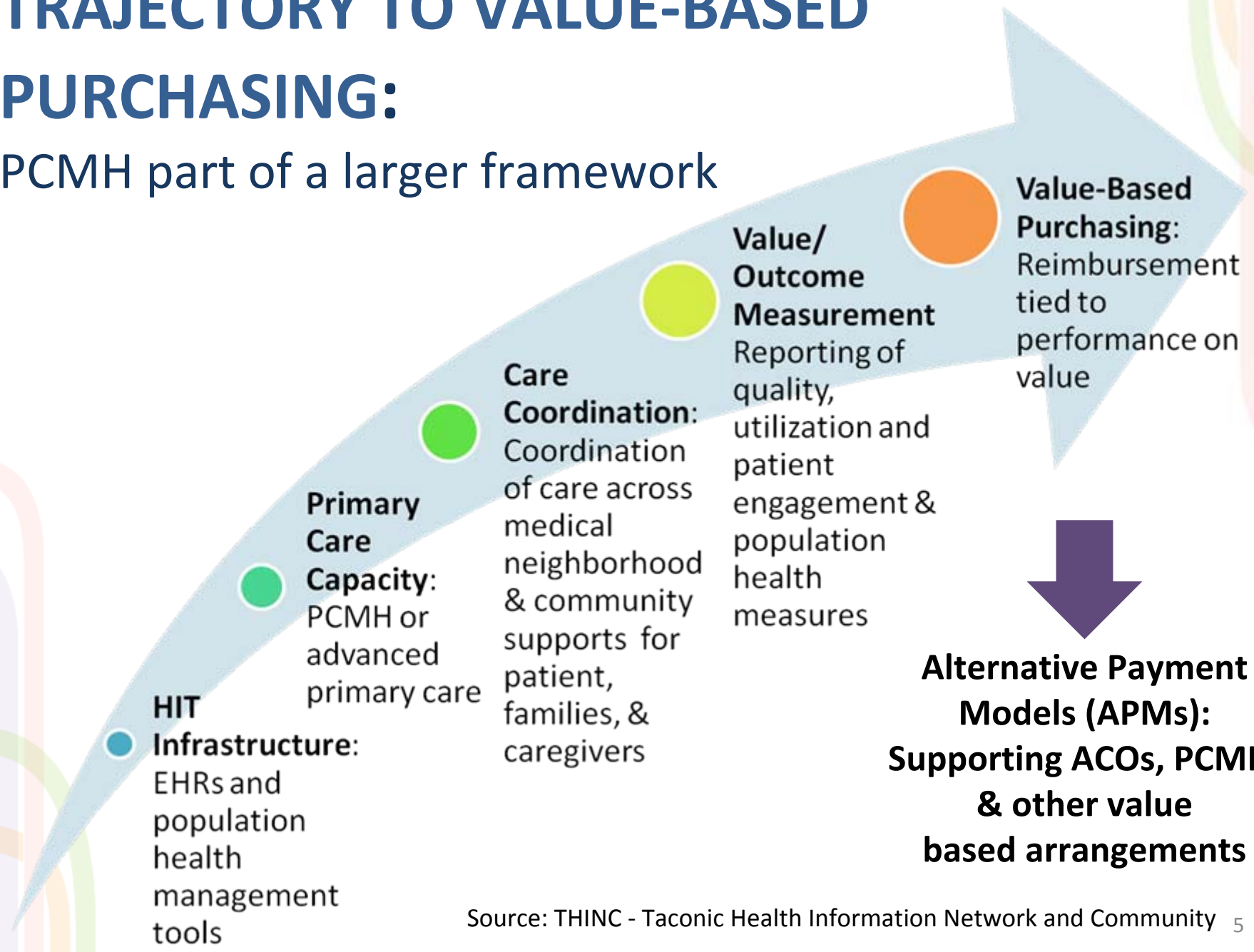

Source : Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." *Health Affairs* 27.3 (2008): 759-769.

# PATIENT-CENTERED PRIMARY CARE



# TRAJECTORY TO VALUE-BASED PURCHASING:

PCMH part of a larger framework




Source: THINC - Taconic Health Information Network and Community

# "EACH SYSTEM PERFECTLY DESIGNED TO ACHIEVE RESULTS IT GETS"

**Confronting a Changing Paradigm: The Evolution of Incentives for Providers**

| | Fee for Service | DRG/Quality Cost Incentives | Accountable Care |
|---|---|---|---|
| Patient Volume | ▲ | ▲ | ▼ |
| Length of Stay | ▲ | ▼ | ▼ |
| Ancillary Testing | ▲ | ▼ | ▼ |
| Health Care Environmental Paradigm | • System formation and expansion, market consolidation<br>• Volume driven primary and specialty care | • Continued expansion<br>• Emergence of quality and safety processes and metrics<br>• Increased transparency on pricing and outcomes | The "Triple Aim" (Value)<br>• Improve the experience of care<br>• Improve the health of populations<br>• Reduce the per capita costs of health care<br>• Accept "integrator" role<br>• Two-way risk sharing<br>• Appropriate utilization |

▲ UP
▼ DOWN

http://www.dartmouth-hitchcock.org/about_dh/new_reimbursement_models.html

# GETTING EMPLOYERS & HEALTH PLANS ENGAGED

Employers knowing their workforce, engaging and educating employees in their own health – where they live, work, and play (mHealth tools, & population health strategies)

Employers, health plans, and providers developing contracts that incentivize value (demand and supply side) to drive down total cost of care and improve population health

Linking to multi-payers initiatives in your local region/state to promote alignments in payment & push for reform

# NEW PRIMARY CARE MULTI-PAYER OPPORTUNITY

Table. Comparison of the Design Features of CPC and CPC+ Tracks 1 and 2

| | CPC | CPC+ Track 1 | CPC+ Track 2 |
|---|---|---|---|
| Size | 7 Regions; ≈500 practices | ≤20 Regions; ≤2500 practices | ≤20 Regions; ≤2500 practices |
| Duration | 4 y (2012-2016) | 5 y (2017-2021) | 5 y (2017-2021) |
| Medicare care management fee[a] | $20 PBPM PY1-2; $15 PBPM PY3-4; average across 4 risk tiers | $15 PBPM average across 4 risk tiers | $27 PBPM average across 5 risk tiers; $100 for highest-risk tier |
| Medicare payment for office visits | 100% FFS | 100% FFS | 100% FFS for non-evaluation and management; reduced FFS + up-front payment for evaluation and management |
| Medicare incentive payment | Shared savings based on quality metrics and TCOC[b] | $2.50 PBPM based on quality and utilization metrics | $4 PBPM based on quality and utilization metrics |
| HIT partners | Not required | Not required | Required |

http://jama.jamanetwork.com/article.aspx?articleid=2513625

# "MACRA'S COMING"

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a *bipartisan* legislation signed into law on April 16, 2015


- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

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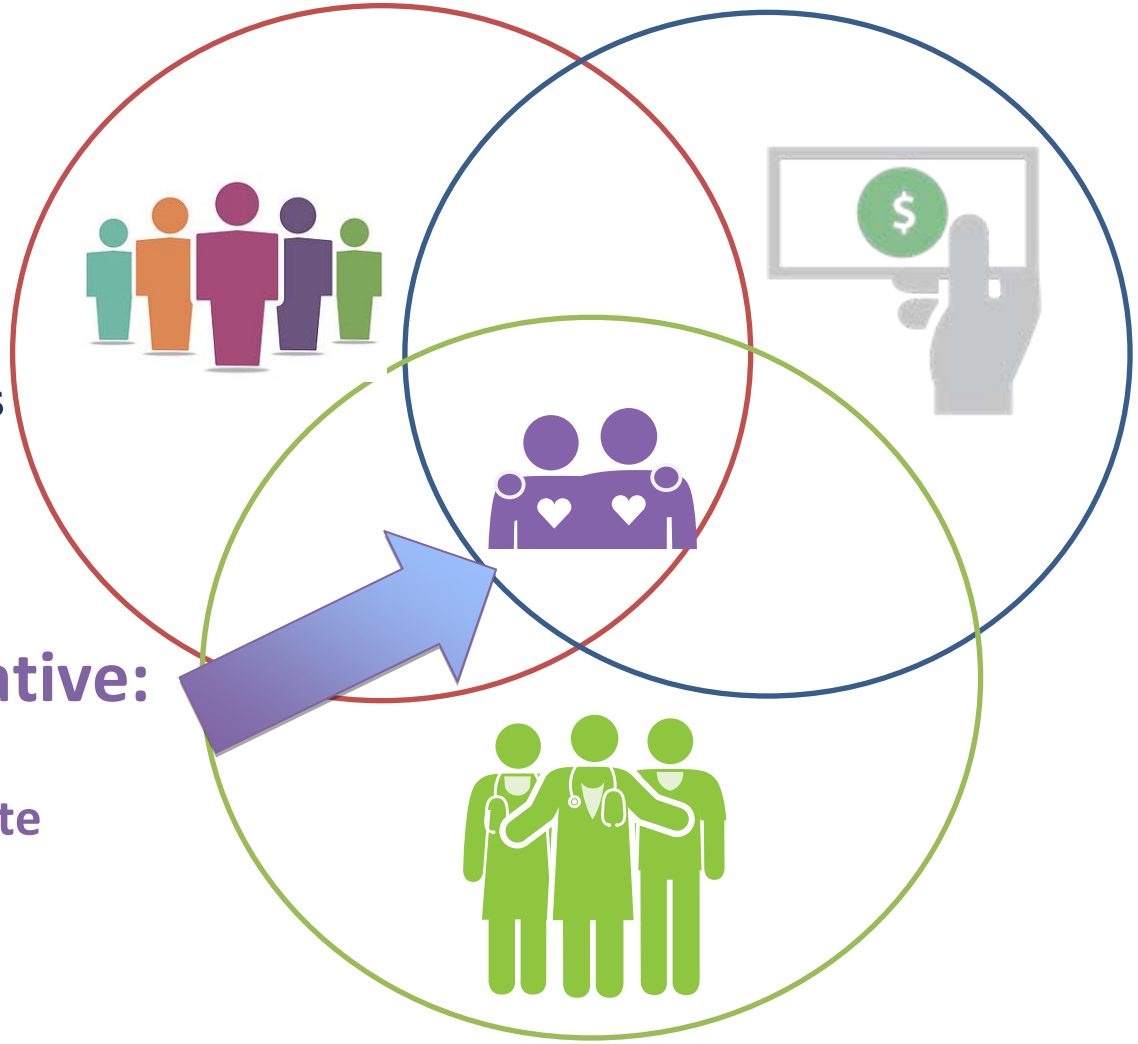
# PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

***Unifying*** **for a better health system --- by better investing in** ***team-based*** **patient-centered primary care**

**PUBLIC:**
**Patients,**
**Families,**
**Caregivers,**
**Communities**



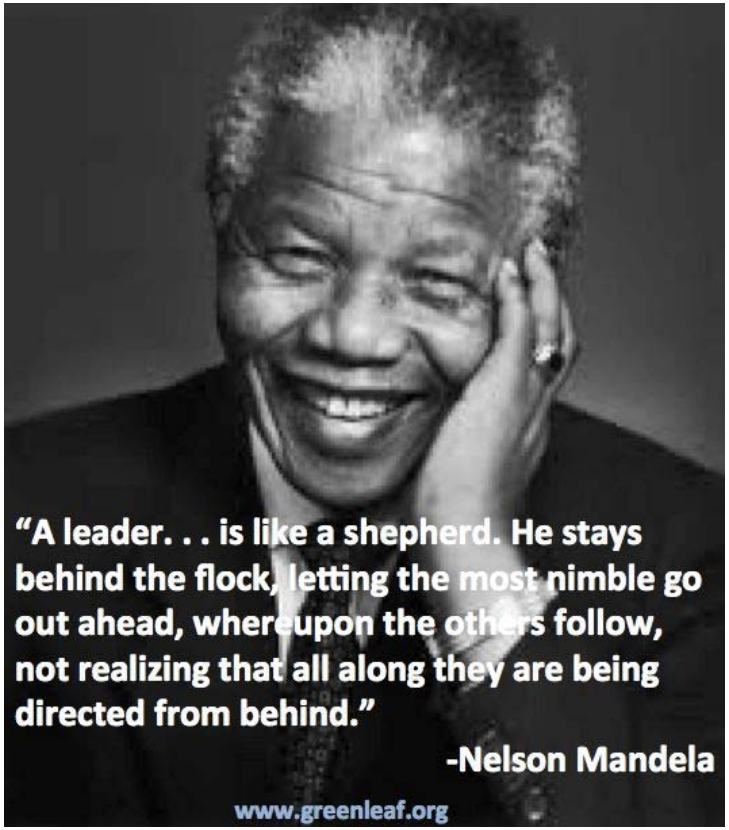
**PAYERS:**
**Employers,**
**Government,**
**Health plans,**
**Consumers**

**Collaborative:**
- **Convene**
- **Communicate**
- **Advocate**

**HEALTH CARE PROVIDERS: People who take care of patients/families**

# TRANSFORMING PRIMARY CARE: LEADERSHIP REQUIRED

"It takes leadership, and leadership of a particular kind. The creation of integrated, comprehensive primary care is not a technical proposition. **Clinicians are not line workers who produce bits of health care, and clinics are not factories where health care is made**. … Health is personal …"




DeGruy, F (2015) Integrated Care: Tools, Maps, and Leadership
J Am Board Fam Med September-October 2015 vol. 28no. Supplement 1 S107-S110

Patient-Centered Primary Care COLLABORATIVE

# THANK YOU!

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