Challenge and Opportunity in a Capitated Medical Home Swedish Community Health Medical Home at Year Two 1/2

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Medical Home Clinic Pilot

Goal and Objectives

"Our patient's health is our bottom line"

- Practice medical home concepts
- Offer longer visits
- Utilize a PMPM payment model
- Attain financial viability

A

TREATISE

OF THE

HYPOCHONDRIACK

AND

HYSTERICK

PASSIONS,

Vulgarly call'd the HYPO in MEN and VAPOURS in WOMEN;

In which the SYMPTOMS, CAUSES, and CURE of those DISEASES are set forth after a Method intirely new.

The whole interspers'd, with Instructive Discourses

ON THE

Real ART of PHYSICK it self;

And Entertaining Remarks on the Modern Practice

OF

PHYSICIANS

AND

APOTHECARIES:

Very useful to all, that have the Misfortune to stand in need of either. In Three Dialogues.

By *B. DE MANDEVILLE*, M. D.

Scire potestates herbarum, usumque medendi
Maluit, & Mutas agitare inglorius artes.

Æneid. Lib. XII.

LONDON: Printed and Sold by *Dryden Leach*, in *Elliot's* Court, in the *Little-Old-Baily*, and *W. Taylor*, at the *Ship* in *Pater-Noster-Row*. 1711.

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THE FIRST

DIALOGUE

BETWEEN

Philopirio a Physician,

AND

Misomedon his Patient.

Misomed. I Have sent for you, Doctor, to consult you about a Distemper, of which I am very well assured, I shall never be Cured.

Philopir. Whatever your Case may be, Sir, it is a great misfortune, you entertain so ill an Opinion of it; but I hope, your Disease may prove less desperate than your Fears.

Mis. It is neither better nor worse than I tell you, and what I say, is what I am convinc'd of by Reason, and not a suggestion of my Fears: But you think, perhaps, I m a Mad Man, to send for a Physician, when I know before-hand, that he can do me no good: Truly, Doctor, I am not far from it: But first of all, Are you in haste, 'pray'?

Phi. Not in great haste Sir.

Mis. I am glad of that; for most of your Profession always either are, or at least pretend to be in a great hurry. But tho' you are at leisure, Can you hear a Man talk for half an Hour together, and, perhaps, not always to the purpose, without interrupting him? For I have a great deal to say to you, several Questions to ask you, and, know I shall be very tedious; but if you can bear with me, I'll consider your Trouble, and pay you for your Time, and Patience both. Can you stay an Hour?

Phi. Yes, Sir, or longer, if there be occasion.

Pilot Medical Home Clinic

- Practice medical home concepts
(with limited staff)
- Offer longer visits
(with providers and RNs 'doing it all')
- Utilize a PMPM payment model
(including self pay, Medicaid, Medicare, commercial insurance and charity care for broad residency training)
- Attain financial viability

Advantage of Longer Visits

- 60 minute visits = 50+ minutes for history, exam, chronic disease management, education, assessment and plan

or

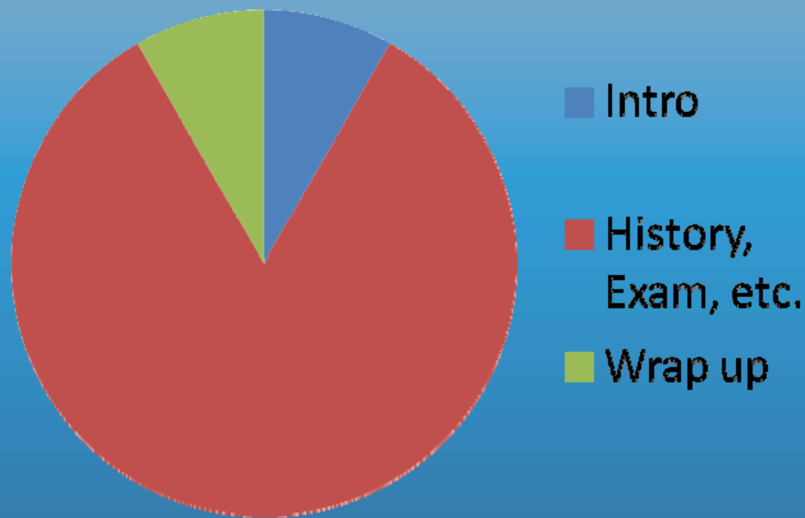
- 20 minute visits = 10+ minutes for same

It would take five (or three) shorter visits to provide the
same services to the patient

Visit Time Comparison

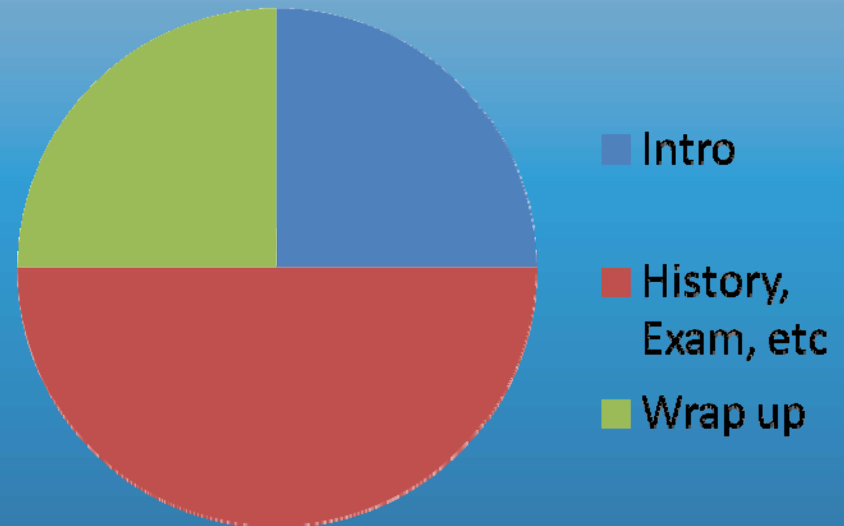
60 minute visit

1 Appointment – 50 minutes



20 minute visits

5 Appointments – 50 minutes



Patient Satisfaction

Longer visits

- Time to cover entire problem list and HCM
- Patient feels valued and known to provider and staff
- Future contacts are more easily done over the phone or by email

Shorter visits

- All problems not dealt with and no time for HCM
- Takes a year or two to get to know your provider and vice versa
- Staff doesn't know patients well enough to be comfortable with phone, email visits

One email Testimonial after First Visit and Email Follow-up

“Fantastic! Thank you so much for your thorough evaluative summary of my health. I really appreciate your time and love, love, love the service you provide. I look forward to my health partnership with you and Swedish!”

Premera Survey – Feb 2011

Provider Care

- 98% felt providers always (77%) or usually spent enough time with them
- 97% felt providers always (76%) or usually listened carefully to them
- 97% felt providers always (76%) or usually explained things in a way that was easy to understand

Medical Home

- 20% used email
- 90% felt they always (69%) or usually got care right away when they needed it
- 92% felt that their providers talked about the pros and cons of each choice for treatment

Favorite things about clinic 90% plan to re-enrolling

- Same day appointments
- 60 and 30 minute visits
- Waived cost share
- Team approach

Fewer, and initially longer. visits for relatively healthy patients allows for more frequent but still overall fewer and longer visits for more complex patients

Once you know a patient it is easier and safer to help manage their health over the phone and by email

Too good to be true?

Long visits sound nice but how do we make ends meet?

Do away with FFS billing!

Pilot Clinic

Goal and Objectives

"Our patient's health is our bottom line"

Practice medical home concepts - yes

Offer longer visits - yes

Utilize PMPM payment model

Attain financial viability

Our Financial Plan is Based on ‘Primary Care’ Capitation

Definition of capitation: A clinic is paid a contracted rate for each enrollee, referred to as "per-member-per-month" (PMPM), to cover a defined scope of services. The contractual rates are, in some cases, adjusted for age. No limit to number of visits.

FFS Encourages Short Visits

- One hour visit – 99215 ($120)
- Two thirty minute visits – 99214 ($190)
- Three twenty minute visits – 99213 ($195)
- Three twenty minute visits– 99214 ($285)
- Four fifteen minute visits – 99213 ($260)
- Four fifteen minute visits – 99214 ($380)
- Strong financial motivation to see a lot of patients – 30/day common

Swedish Community Health Medical Home Finances

Fully Realized Clinic

- 2500 patients
- 6 residents
- 3 faculty
- 1 ARNP
- 2 RNs
- 2 Receptionists
- 1 Clinic Manager
- $112,500/month
- 100% PMPM

Where We Are at Present

- 1800 patients
- 6 residents
- 3 faculty
- 1 ARNP
- 1 RN
- 2 Receptionists
- $62,000/month
- 75% PMPM

PMPM Self Pay

- 60 minute visits – PMPM – $660/year (5 visits at $120 per visit FFS)
- 30 minute visits – PMPM –$660+/year (7 visits at $95 per visit FFS)
- Allows for phone and email visits and care management

Patient Panel

- 20 – 40% Self Pay PMPM
- 30 – 50% Medicaid (20% Medicaid FFS, 80% commercial for-profit PMPM (Molina)
- 10% Medicare FFS
- 20 – 25% commercial not-for-profit insured PMPM (Premera)
- 75-80% PMPM (goal 100%)

Patient Panel

- Self Pay PMPM – $45 -> $55/month
- Medicaid FFS – varies
- Medicaid Capitated – $25 /month
- Medicare FFS – varies
- Commercial Capitated – $35/month
- Charity Care

Two Other Capitated Clinics in Seattle

Clinic A

- Privately insured concierge care
- $209/month
- 60 –30 minute visits
- 3 year pilot
- 2 FTE physicians
- < 200 patients enrolled
- < $40,000/month
- Clinic closed 2011

Clinic B

- Privately or uninsured 'affordable' concierge care
- $50-$90 based on age ($100 registration fee)
- 30- 60 minute visits
- Opened June 2007 as blueprint for the country
- Expanding to 5 sites this fall
- $10,000,000 grant

Unanticipated Challenges

Patient Panel and Insurers

- No health care for years -> more visits up front
- Contracts with one for-profit and one not-for-profit insurance plans lower capitation than anticipated
- Patients overall more complex – not many relatively well patients – common in residency clinic

Overstaffed/Understaffed

- Need to overstaff initially
- Turnover of staff – wearing too many hats
- Unanticipated billing needs
- Unanticipated need for data collection from contracted insurers
- Self Pay patients sometimes don’t pay
- More services offered than clinic could afford

Will it Work?

Challenges

- Challenge to maintain longer visits - RRC still requiring residents to see 1650 visits
- May be able to count phone and email visits for residents but can't bill FFS
- Our patients' health is our bottom line – need to prove decreased ED visits and decreased hospitalizations, improve overall health of panel of patients and decrease cost for insurers

Opportunities

- More short acute visits – but still time to update HCM, chronic disease management by RN
- Need to use team to manage more patients over phone and email so providers can spend extra time with patients
- Increase proportion of PMPM patients and charge enrollment fee and/or raise monthly
- Better contracts with insurers after convincing them of cost effectiveness of care

How might we look at year 3

1) Fewer patients on commercial insurance – no cost savings because of well patients but reimbursement was lower than PMPM

2) More self pay patients – penalty for dropping out or enrollment fee

3) More charity care patients who now use the ED for their primary care - will save the hospital enough money to support the clinic

Pilot Clinic

Goal and Objectives

“Our patient’s health is our bottom line”

Practice medical home concepts – yes

Offer longer visits – yes

Utilize PMPM payment model – yes and no

Attain financial viability – not yet

Will it work?
Were we too far ahead of our time?

With some changes we
may survive

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