Case Studies - Patient Centered Medical Home

A 360 Degree View of the Medical Home in Action

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- 339 Total Providers
  - 242 Physicians
    ✓ 111 Adult Medicine Physicians
    ✓ Family Practice, Internal Medicine, Hospitalists, Urgent care
    ✓ 38 Pediatricians
    ✓ 36 OB-Gyns
    ✓ 57 Medical and Surgical Specialists
    - 97 Midlevel practitioners
- 74 Practice sites within the Group
  - 22 sites involved in the BTE P4P Project
Need for Transformation in the way Healthcare is delivered

• Healthcare 2015 IBM report states that the US Healthcare system is on an unsustainable path that will force a transformation...to reduce cost and increase quality of care.
• Currently care is episodic: treatment delivered at time of visits, inconsistent care in between visits
• Clinical information is scattered: different data presented in numerous disconnected systems
• Presentation of incomplete data: causes delays in treatment and increased cost.
Payer Challenges

• Healthcare decisions made with incomplete patient records drive costs higher
• Transition from episode based care to cycle of care has been difficult
• Limited mechanisms for implementing value-based models for the provision of healthcare services
• Provider skepticism about clinical data integration across the full healthcare cycle
Provider Challenges

• Limited to episode based care due to inadequate access to the patient’s healthcare community
• Individual provider records are not kept in a form that is easy to integrate across the patient’s full care cycle
• Coordinating patient’s healthcare with payer plan preferences at the time of treatment
• Trusting health plans as “partner” in patient’s healthcare
Requirements for a Successful Model

- Acceptable to patients, employers, and physicians
- Easily understood by all parties
- Sustainable
- Have incentives aligned
- Measurable outcomes
- Have a return on investment at level of DM Programs for MC
- Promote documented improvements in Health Outcomes and health care processes
Humana /Wellstar Pilot

Douglasville Medical Center
East Paulding Primary Care Center

A Medical Home Model

May 2008
Physician Motives to Participate

• Potential for more satisfying work environment with potential for better care and improved reimbursement
• Team approach to support management of patients and broad knowledge base required for primary care with new knowledge coming every year
• Reimbursement to support pilot/acquisition of tools and transition to improved care processes
• Potential for future reimbursement based on quality - not quantity
Payer Incentives to Partner

• Collaboration: Access to payer and provider based information provides the opportunity for data sharing, as a first step in developing a partnership with providers in the patient’s healthcare management built on trust.

• Coordination: Develop processes to aggregate patient's healthcare data enhancing value of each visit and providing opportunity for better care management over time and among multiple resources.
WellStar’s Motives to Participate

- Feedback to contracting for future negotiations with managed care
- Opportunity for practices to become recognized as PCMH by NCQA
- Increased patient, physician and staff satisfaction
- Better clinical outcomes
- Decreased costs of care over population - decreased ER visits and Inpatient Admissions and LOS
- Decreased cost of specialty care
- Increased payments to primary care
- Increased interest in primary care as career
Practice Experience - After 9 Months

- Minimal quality improvement initially - much work had already been done through BTE
- Process improvement work has yielded cost reduction and improved provider satisfaction
- Financial investment and shared potential provides incentive to do the “work” of change
- IT solutions necessary
Practice Challenges

• Time
• Access
• Funding the change
• Need for more licensed staff for practice support
  - Integration of Proactive patient management
  - Transition from individual patient to patient/family and population management
Physician Challenges

- Facing reality that “Usual care is not good enough”
- Chronic conditions last a lifetime
- Division of labor and accountability between patient, family, practice
- Awareness of how to connect to community
- EMR Transition
Medical Home Challenges

• Accepting that old way won’t work in order to embrace different practice
• Medical Home verbiage not easily grasped by provider, patient and staff
• Connections to support services, information, community
• Transition to supporting self-management and shared decision making
• Shift from individual to family centered care
<table>
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<tr>
<th>Metric</th>
<th>5/1/08 – 9/30/08 Wellstar</th>
<th>5/31/08 – 9/30/08 Wellstar</th>
<th>Control Group</th>
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<tbody>
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<td>ER Utilization</td>
<td>$5.84 PMPM</td>
<td>$6.20 PMPM</td>
<td>$6.20 PMPM</td>
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<td>↓ 32%</td>
<td>↓ 10%</td>
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<td>Inpatient</td>
<td>$76.47 PMPM</td>
<td>$92.34 PMPM</td>
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<td>↑ 17%</td>
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<tr>
<td>PAR Facility</td>
<td>92%</td>
<td>93%</td>
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<tr>
<td></td>
<td>↑ 13%</td>
<td>↑ 4%</td>
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<td>Generic Dispense Rate</td>
<td>67%</td>
<td>68%</td>
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<td></td>
<td>↑ 5%</td>
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<td>Diagnostic Imaging Cost</td>
<td>$40.83 PMPM</td>
<td>$40.04 PMPM</td>
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<td>↓ 17%</td>
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<tr>
<td>Primary Care Office Visits</td>
<td>$8.53 PMPM</td>
<td>$8.64 PMPM</td>
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<tr>
<td></td>
<td>↑ 2%</td>
<td>↑ 3%</td>
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Note: % change compared to respective baseline
Future Rewards

- Financial rewards for improved results/outcomes
- Practice transformation skills for continued improvement
- Cultural change
  Comfort with identifying needs and bad processes with resulting negative outcomes
  Improved communication between physicians and staff
  Staff involved in “how” to do their jobs
Value to the Healthcare Community

• Enhanced Quality of Care
  – Better processes through technology and information provide clinical flags for care, based upon evidence based medicine.

• Lower Disease Management, Case Management and administrative costs
  – using technology to replace paper and telephone

• Contributes to healthcare reform and more initiatives like Medical Home

*To Err is Human, Institute of Medicine, Novem*
Critical Success Factors

• Quality Measures
  - Clinically sound, nationally recognized and accepted
  - Both Outcome and Process measures

• Reimbursement Alignment
  - Physicians, Employers, Payers

• Strong Implementation Team
  - Practice staff involvement at all levels
  - Outside support for initial data collection and process improvement

• Regular meetings with physicians/payers
  - Identify issues and reinforce goals through concise information and data

• Use of New Technology
  - EMR will be critical going forward
An Electronic Medical Record

• Patient information instantly available for all team members
• Integrates decision support/patient safety tools for POS care delivery
• Allows information sharing across physicians
  – improving communication and decision making
  – reducing chance for errors
  – eliminating redundant services
• An information platform from which results and metrics can be easily extracted to provide useful data and reporting
• Lowers the cost of maintaining manual records
• Great economic incentives for both providers and payers
HIT Challenges and Success Factors

A train coming at you or light at the end of the tunnel?
About NextGen Healthcare Information Systems

• NextGen Healthcare provides integrated electronic health record (EHR) and practice management systems, connectivity solutions, and billing services for hospitals and ambulatory practices.

• Formalized Health Quality Measures Outcomes Program in 2007

• Work with clients to leverage NextGen Health Quality Reporting Module as well as “operationalize” outcomes reporting and P4P programs within their practice

• Further supported by Grants and Funding Services
Top 5 HIT Challenges

1. PCMH is in its infancy
   - Variations in payer reporting requirements
   - Variations in definition of PCMH

2. Administrative Reporting
   - Written procedures
   - Operational performance

3. Clinical Tracking
   - Discrete Clinical Data Element Capture
   - Patient Outreach/Self-Management
   - Care Management Planning and Execution
   - Referrals
   - Orders
   - External Diagnostic Tests

4. Measurement
   - Claims vs. Clinical Data
   - Integrated reporting for all PCMH requirements

5. Financial and clinical analysis for operational efficiencies
Integration is Key...
Transformation from Data Rich to Information Rich!

- Integrated reporting of Practice Management and EHR data
- Seamless clinical data point capture during course of documenting encounters/physician workflow
- Work log tasks integrated into outcomes reporting
- Automated solutions to increase patient care and practice efficiencies
  - Patient outreach
  - Follow-up care
- Assistance in mapping PCMH requirements into Practice Management and EHR solution
Thank You

Q&A

For questions about this presentation contact:
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