Patient-Centered Primary Care COLLABORATIVE

The Patient-Centered Medical Home: Setting the Stage

A presentation to the 13th Population Health Colloquium and Fifth National Medical Home Summit

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Why is the Patient-Centered Medical Home (PCMH) getting so much attention?

Unsustainable growth of health spending



Source: Center for American Progress, 2012

Federal Health Care Costs

Revenues and Primary Spending, by Category, Under CBO's Long-Term Budget Scenarios Through 2080



⁵ Source: Congressional Budget Office, "The Long Term Budget Outlook", August 2010

Health care expenditure per person

by source of funding, 2007*



Source: OECD Health Data 2009 (June 2009), Commonwealth Fund

Projected cost of health care

PHYSICIAN	YEAR OF NURSING	MRI PERFORMED	FAMILY
OFFICE VISIT	HOME CARE	IN HOSPITAL	PREMIUM
		P	
Recent price: \$89 (2011)	Recent price: \$78,110 (for a semiprivate room, 2011)	Recent price: \$1,080 (2011)	Recent price: \$15,073 (2011)
Rate of growth:	Rate of growth:	Rate of growth:	Rate of growth:
+ <mark>66</mark> %	+ <mark>64</mark> %	+ 69%	+ 73%
2021	2021	2021	2021
projected price:	projected price:	projected price:	projected price:
\$148	\$128,100	\$1,826	\$26,076

Sources: Center for American Progress Analysis; Kaiser Family Foundation: Employer Health Benefits Summary, 2011; MetLife: Market Survey of Long-Term Care Costs, 2011; International Federation of Health Plans: 2011 Comparative Price Report, 2011

Source: Center for American Progress, 2012

Cost of health care "waste"

Key sources of waste ¹	% of total medical cost that is waste
Admin and system	4 - 6%
Provider inefficiencies	3 - 4%
Lack of care coordination	1 - 2%
Unwarranted	11 - 21%
Preventable conditions and avoidable care	1 - 2%
Fraud and abuse	5 - 8%
(~30%

Conservatively, 30% of the annual \$2.5 trillion U.S. health expenditure is estimated to be waste, equating to approximately \$700B each year.



¹Thomson Reuters, 2011

Solutions point to primary care

Significant problems

Rising healthcare costs → \$2.4 trillion (17% of GDP)

Gaps/variations in quality and safety

Poor access to PCPs

Below-average population health

Aging population
 Chronic disease

... "Experiments" underway

- PCMHs
- ACOs
- EHR/HIE investment
- Disease-management pilots
- Alternative care settings
- Patient engagement
- Care coordination pilots
- Health insurance
- exchanges
- Top-of-license practice

... Primary carecentric projects have proven results

Across 300+ studies, better primary care has proven to increase quality and curtail growth of health care costs

What are we actually referring to when we say "PCMH"?

What is a medical home? The medical home is an *approach* to primary care that is: Patient-Centered Supports patients in managing decisions and care plans. Comprehensive Coordinated Whole-person care provided by Care is organized across a team the 'medical neighborhood' ommitted to Accessible quality and Care is delivered with short waiting times, 24/7 access safety and extended in-person Maximizes use of health IT, hours. decision support and other tools



Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies	Potential Impacts
Patient-Centered	Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels	 Dedicated staff help patients navigate system and create care plans Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status, compassionate/culturally sensitive care 	Patients are more likely to seek the right care, in the right place, and at the right time
Comprehensive	A team of care providers is wholly accountable for patient's physical and mental health care needs – includes prevention and wellness, acute care, chronic care	 Care team focuses on 'whole person' and population health Primary care could co-locate with behavioral, oral, vision, OB/GYN, pharmacy, etc Special attention paid to chronic disease and complex patients 	Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated
Coordinated –	Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health	 Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc. Communication and connectedness is enhanced by health information technology 	Providers are less likely to order duplicate tests, labs, or procedures Better management of chronic diseases and other illness improves health outcomes Focus on wellness and prevention reduces incidence /
Accessible	Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations	 Implement efficient appointment systems to offer same-day or 24/7 access to care team Use of e-communications and telemedicine to provide alternatives for face-to-face visits and allow for after hours care 	
Committed to quality and safety	Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions	 EHRs, clinical decision support, medication management to improve treatment & diagnosis. Establish quality improvement goals; use data to monitor & report about patient populations and outcomes 	severity of chronic disease and illness Lower use of ER & avoidable hospital, tests procedures & appropriate use of medicine = \$ savings

A Change in Paradigm

Today	Future	
Treating Sickness / Episodic	Managing Population	
Fragmented Care	Collaborative Care	
Specialty Driven	Primary Care Driven	
Isolated Patient Files	Integrated Electronic Record	
Utilization Management	Evidence-Based Medicine	
Fee for Service	Shared Risk/Reward	
Payment for Volume	Payment for Value	
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations	
"Everyone For Themselves"	Joint Contracting	

PCMH and Accountable Care: Two Sides of the Same Coin

Accountable Care



Health IT Infrastructure

Trajectory to Value-Based Purchasing It is a journey, not a fixed model of care



Value-Based

How is this different than the 1990s?

Accountable Care

- First and foremost, providers
- "Gateway" to system through primary care
- Mix of Fee-For-Service (FFS) with shared saving; shared savings and shared risk; or partial capitation
- Payment also linked to quality targets

Capitated Managed Care

- First and foremost, **insurers**
 - "Gatekeeping" that limited provider choice
- Full capitation where providers carried vast majority of risk
- Rarely included payment linked to quality

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