Patient Centered Medical Home – The Future

@Paul_PCPCC
- participant will understand/be able to discuss the important trend of PCMH in health care
- participant will understand/be able explore the rationale and supporting evidence for PCMH
- participant will understand/be able understand the impact on patients, providers and payers

Disclosure: – I am a full time Employee of IBM  *I WILL NOT* discuss any *pharmaceuticals, medical procedures, or devices*
Away from Episode of Care to Management of Population with Data

The System Integrator
- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management

Community Health

System Integrator

Population Health
Per Capita Health
Public Health
Patient Experience

The System Integrator

Safety and Quality
Whole Person Orientation
Physician Directed Practice
Personal Physician
Care is coordinated and Integrated
Enhanced Access

Community Health
Key principles

• **Personal healer** – each patient has an ongoing personal relationship with a physician for continuous, comprehensive care

• **Whole person orientation** – physician is responsible for providing all the patient’s health care needs or arranging care with other qualified professionals

• **Care is coordinated and integrated** – across all elements of the complex healthcare community

• **Quality and safety are hallmarks of the medical home** – Evidence-based medicine and clinical decision-support tools guide decision-making

• **Enhanced access to care is available** – systems such as open scheduling, expanded hours, and new communication paths between patients, their physician and practice staff

• **Payment is appropriate** – added value provided to patients who have a patient-centered medical home
Smarter Healthcare

36.3% Drop in hospital days
32.2% Drop in ER use
12.8% Increase in chronic medication
-15.6% Total cost
10.5% Drop in inpatient specialty care costs
18.9% Ancillary costs down
15.0% Outpatient specialty down

24 April 2015, Michigan patient-centered medical home program shows statewide transformation of care YEAR 6

- **9.9%** Decrease in adult ER visits
- **27.5%** Decrease in adult ambulatory care sensitive inpatient stays
- **11.8%** Decrease in adult primary care sensitive ER visits
- **8.7%** Decrease in adult high-tech radiology usage
- **14.9%** Decrease in pediatric ER visits
- **21.3%** Decrease in pediatric primary-care sensitive ER visits

4,022 primary care doctors at 1,422 practices around the state in its sixth year of operation. These practices care for more than **1.2 million** BCBSM members.
Payment reform requires more than one dial

Fee for...

health  value  outcome  process  belonging  service  satisfaction
I love herding cats.

I want to thank no one.
Driving factor 1: Unsustainable Cost (USA 2012)
Driving factor 2: Data
**Value Based Care Components**

### Risk Analytics
- Actuarial Cost Analytics
- Contract Management
- Quality and cost reporting

### Practice Analytics
- Physician Efficiency profiles
- Episode Efficiency profiles
- Drug profiles
- Cost of care analysis
- Imaging
- Leakage

### Case Management
**Manage high-cost patients (top 5%)**
- Predictive modeling
- Patient risk stratification
- Readmissions
- ER usage
- Medication management
- Referral management

### Population Management
**Manage entire population**
- Patient Stratification
- Preventive/Chronic gaps
- Visit compliance
- Rx / Lab compliance
- Self management
- ER, Hospital, Readmissions
Leveraging Advanced Analytics for Knowledge-Data Driven Insights:

*Support business continuity and growth*

- Medical literature
- Clinical guidelines
- Key textbooks
- Social determinants

- Claims data
- Health risks & behaviors
- Community-based data
- HR workforce data

**Advanced Analytics**

**Published Knowledge**

**Patient Care & Insights**

- Behcet's Disease: 45%
- Sarcoidosis: 32%
- Lyme Disease: 1%

Closing the *translational knowledge* gap

Enabling new *personalized and population health* insights

*Knowledge/Data-driven Insights for Better Health Decisions and Prevention of the Next 20% Who Could Cost 80%.*
Driving factor 3: Communication
Smart Integration, Customization, and Engagement:
Improve the overall health and vitality of our employees and their families

5 Dimensions of Health:
- Physical
- Mental
- Financial
- Social
- Purpose
Practice transformation away from episode of care

- Preventive medicine
- Chronic disease monitoring
- Medication refills
- Acute care
- Test results

Source: Southcentral Foundation, Anchorage AK
New model of care – putting the patient first

Healthcare Support Team

Case Manager

Chronic disease monitoring

Behavioral health

Acute mental health complaint

Medical Assistants

Point of care testing

Clinician

Preventive medicine

Medication refills

Acute care

Test results

Source: Southcentral Foundation, Anchorage AK
Future healthcare transformation

- Data driven
- Every person has a plan
- Team based
- Managing a population down to the individual
CATASTROPHIC

MARKET VECTORS
- Medicare value based payments
- ACO
- PCMH
- Bundled Payments
- Payer Programs
- CINs

CHRONIC

ENGAGEMENT
- Purpose driven [close care gaps, change behavior, etc.]
- Multimodal
- Behavioral Sciences

AT RISK

ANALYTICS
- Benchmarking
- Reporting / View
- Stratify & Predict

HEALTHY

DATA
- 360° View of Patient [Data Sources: claims, patient reported, hospital, homecare, devices]
- Data model
- API (I/O)
### Today’s Care

| My patients are those making appointments to see me |
| Care is determined by today’s problem and time available today |
| Care varies by scheduled time and memory/skill of the doctor |
| I know I deliver high quality care because I’m well trained |
| Patients are responsible for coordinating their own care |
| It's up to the patient to tell us what happened to them |
| Clinic operations centre on meeting the doctor's needs |

### PCMH Care

| Our patients are the population community |
| Care is determined by a proactive plan to meet patient needs with or without visits |
| Care is standardized according to evidence-based guidelines |
| We measure our quality and make rapid changes to improve it |
| A prepared team of professionals coordinates all patients’ care |
| We track tests & consultations, and follow-up after ED & hospital |
| A multidisciplinary team works at the top of our licenses to serve patients |

Source: Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
Defining the care centered on the patient

- Superb access to care
- Patient engagement in care
- Clinical information systems, registry
- Care coordination
- Team care
- Communication/Patient Feedback
- Mobile – easy to use and available information
Benefit redesign – Patient engagement
Different strategies for different Healthcare spend segments

% Total healthcare spend

% of members

Those with severe, acute illness or injuries

Those with chronic illness

Those who are well or think they are well
PCMH 2.0 in action

Community Care Team

Nurse Coordinator
Social Workers
Dieticians
Community Health Workers
Care Coordinators

A coordinated Health System
Health IT Framework
Global Information Framework
Evaluation Framework
Operations

Public Health Prevention
HEALTH WELLNESS

Hospitals
Specialists
Public Health Prevention
Call & Check Providing support and care for all in the community
Nearly 1/3 traditional Medicare tied to alternative reimbursement models—such as Patient Centered Medical home (PCMH)/ accountable care organizations (ACOs) or bundled payments—by the end of 2016 --- 50% by end 2018

And end of 2018 90% of traditional Medicare payments to quality or value through programs such as the Partnership for Patients Hospital, Value Based Purchasing and the Hospital Readmissions

Senate 92 to 8

https://www.youtube.com/watch?v=UY088YyQ6uA
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- **Alternative payment models** (Categories 3-4)
  - 0%
  - ~70%

- **FFS linked to quality** (Categories 2-4)
  - ~20%
  - >80%

- **All Medicare FFS** (Categories 1-4)
  - 30%
  - 85%
  - 50%
  - 90%

**Historical Performance**

**Goals**