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Patient Centered Medical Home – The Future

@Paul_PCPCC

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Patient Centered Medical Home – The Future

-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

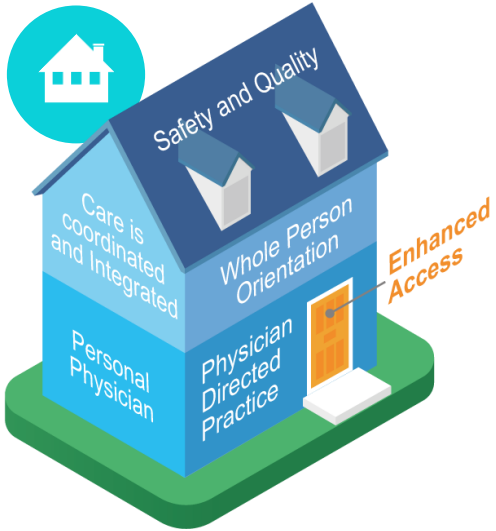
Community Health

The System Integrator

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

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

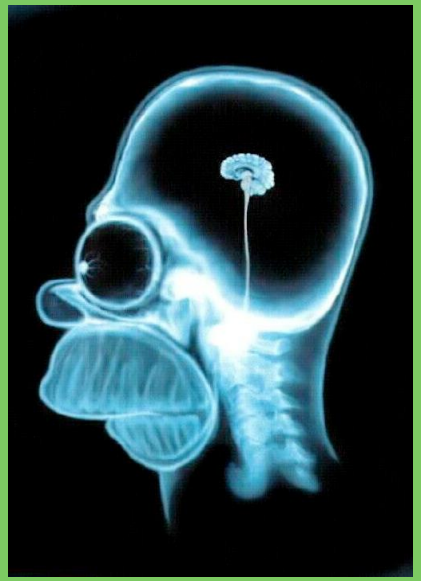
-15.6% Total cost

10.5% Drop in inpatient specialty care costs

18.9% Ancillary costs down

15.0% Outpatient specialty down

Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US – PCPCC Oct 2012



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.

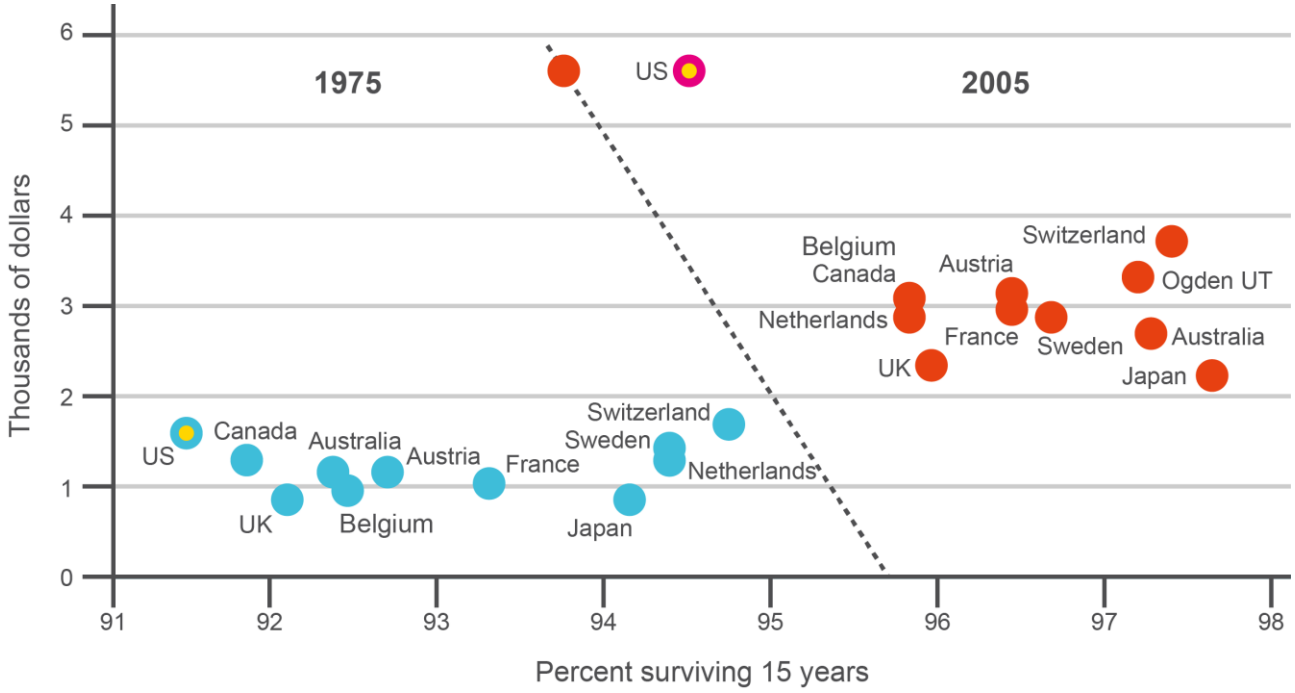
Payment reform requires more than one dial

Fee for...


I ♥
HERDING
CATS


I WANT TO THANK
PURINA
Friskies
Feed The Senses
NO ONE.
Facebook/Friskies

Driving factor 1: **Unsustainable Cost** (USA 2012)



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Driving factor 2: **Data**

VALUE BASED CARE COMPONENTS

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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

ANALYTICS

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

CARE DELIVERY

DATA FOUNDATION

Leveraging Advanced Analytics for Knowledge-Data Driven Insights:

*Support **business continuity** and **growth***

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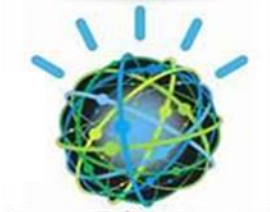
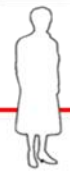
- Medical literature
- Clinical guidelines
- Key textbooks
- Social determinants

Published Knowledge

Advanced Analytics





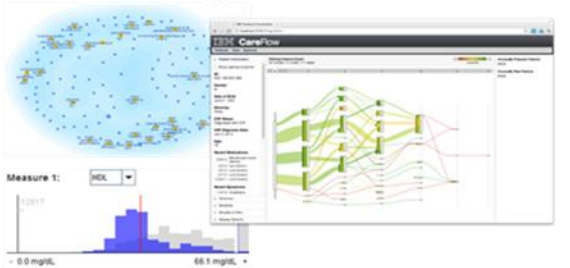
Behcet's Disease	45%
Sarcoidosis	32%
Lyme Disease	1%

*Closing the **translational knowledge** gap*

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

Observational Data

Patient Care & Insights



*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%.*

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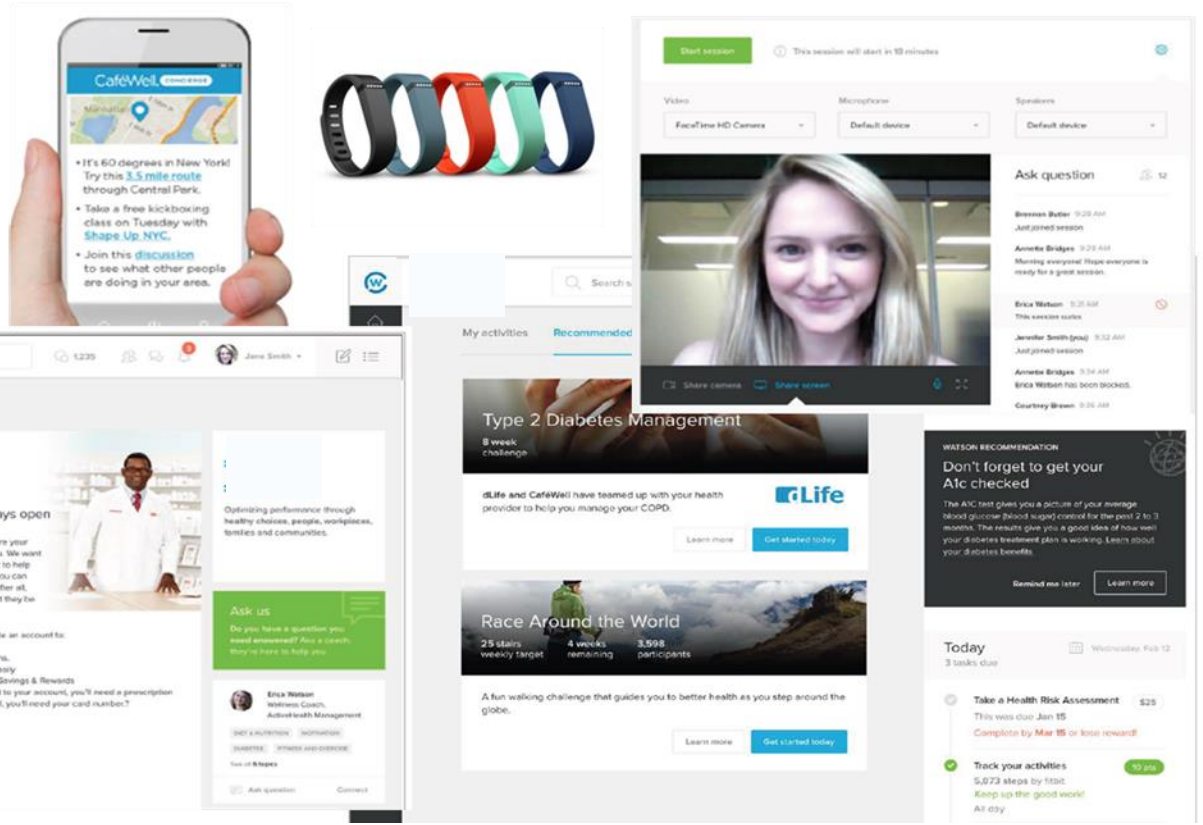
Driving factor 3:
Communication

Smart Integration, Customization, and Engagement:

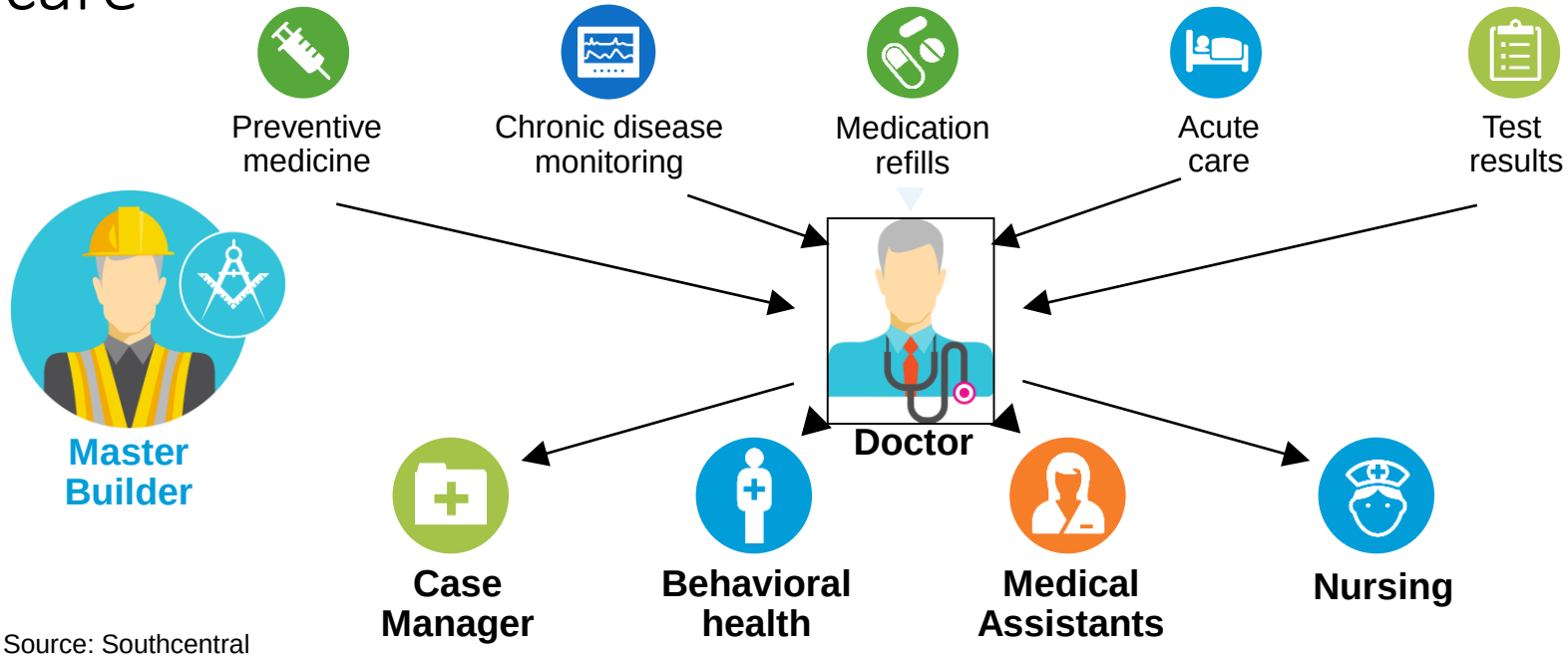
*Improve the **overall health and vitality** of our employees and their families*

5 Dimensions of Health:

- *Physical*
- *Mental*
- *Financial*
- *Social*
- *Purpose*

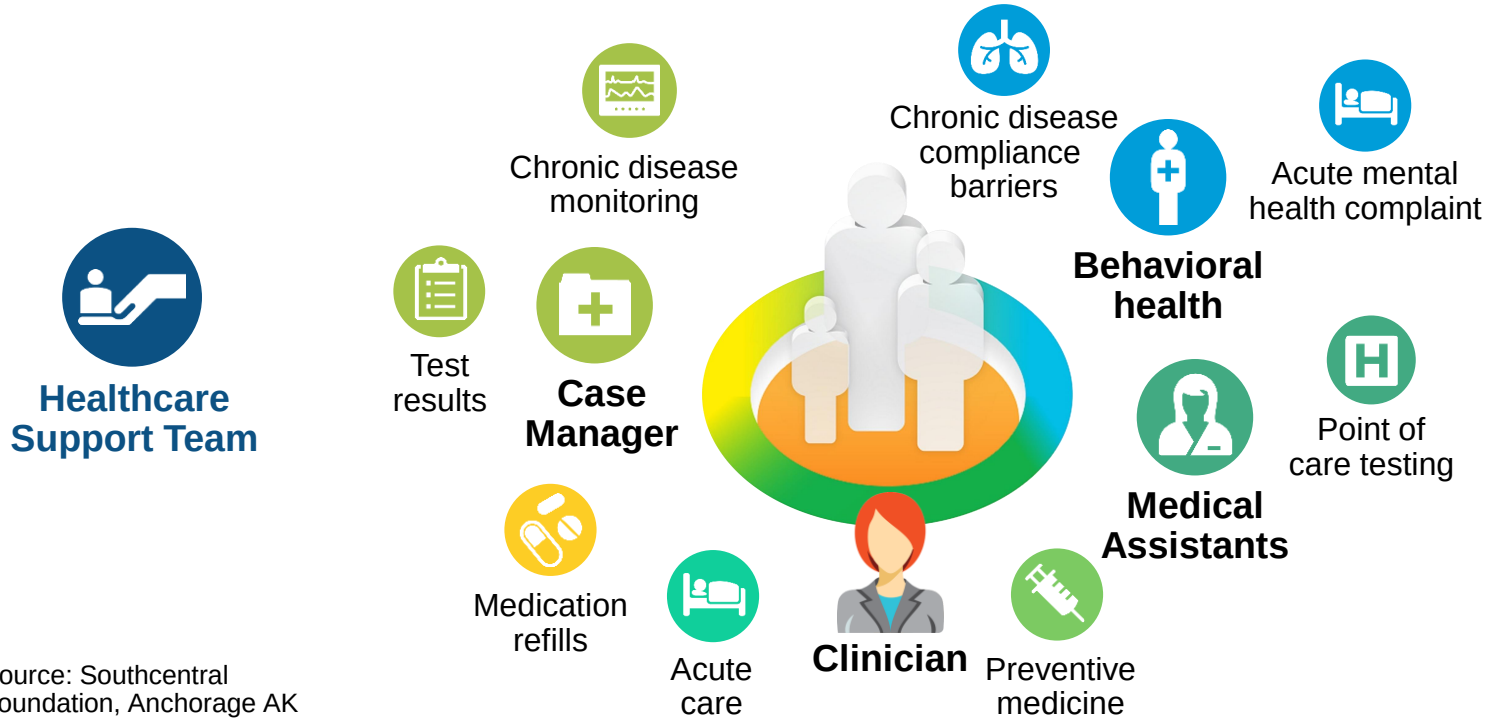


Practice transformation away from episode of care



Source: Southcentral Foundation, Anchorage AK

New model of care – putting the patient first



Source: Southcentral Foundation, Anchorage AK

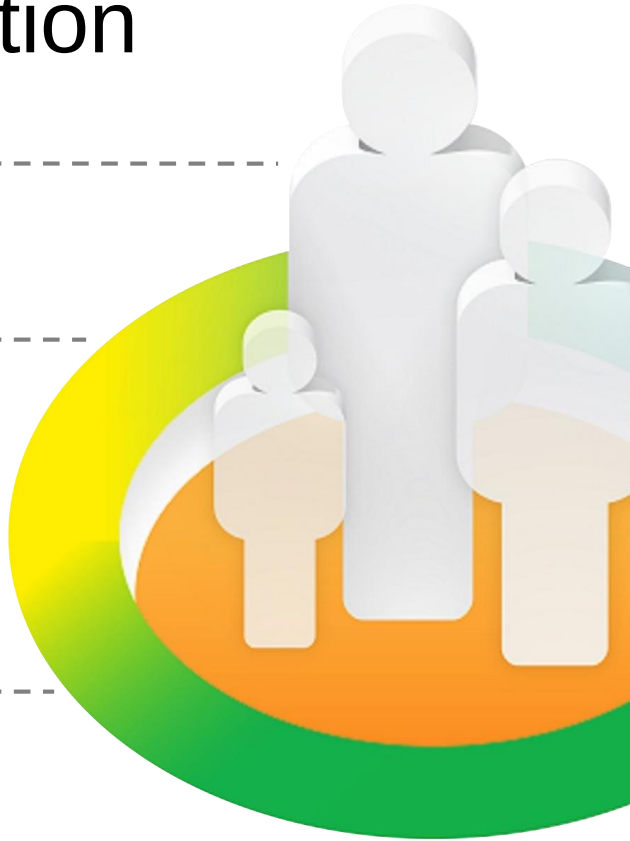
Future healthcare transformation

Data driven

Every person has a plan

Team based

Managing a population down to the individual



MARKET VECTORS

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

ENGAGEMENT	• Purpose driven [close care gaps, change behavior, etc.] • Multimodal • Behavioral Sciences
ANALYTICS	• Benchmarking • Reporting / View • Stratify & Predict
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

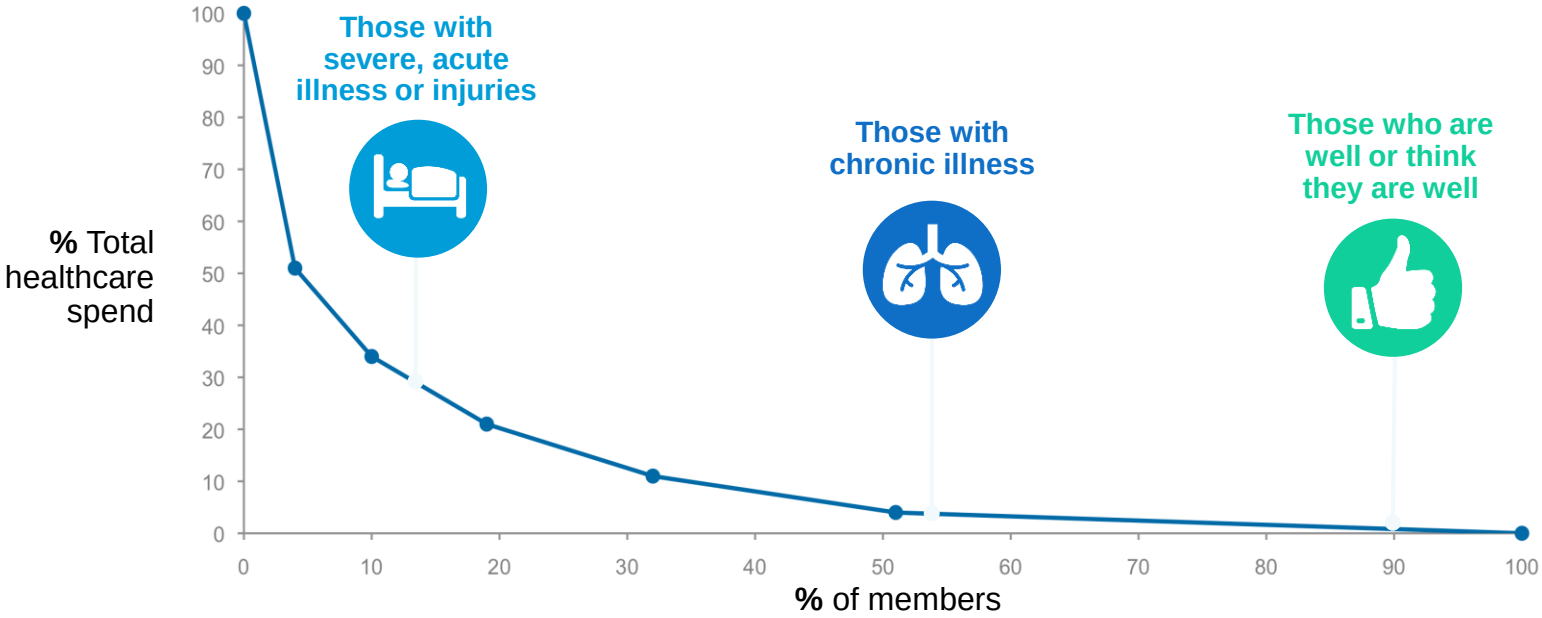
Source:
Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

Defining the care centered on the patient

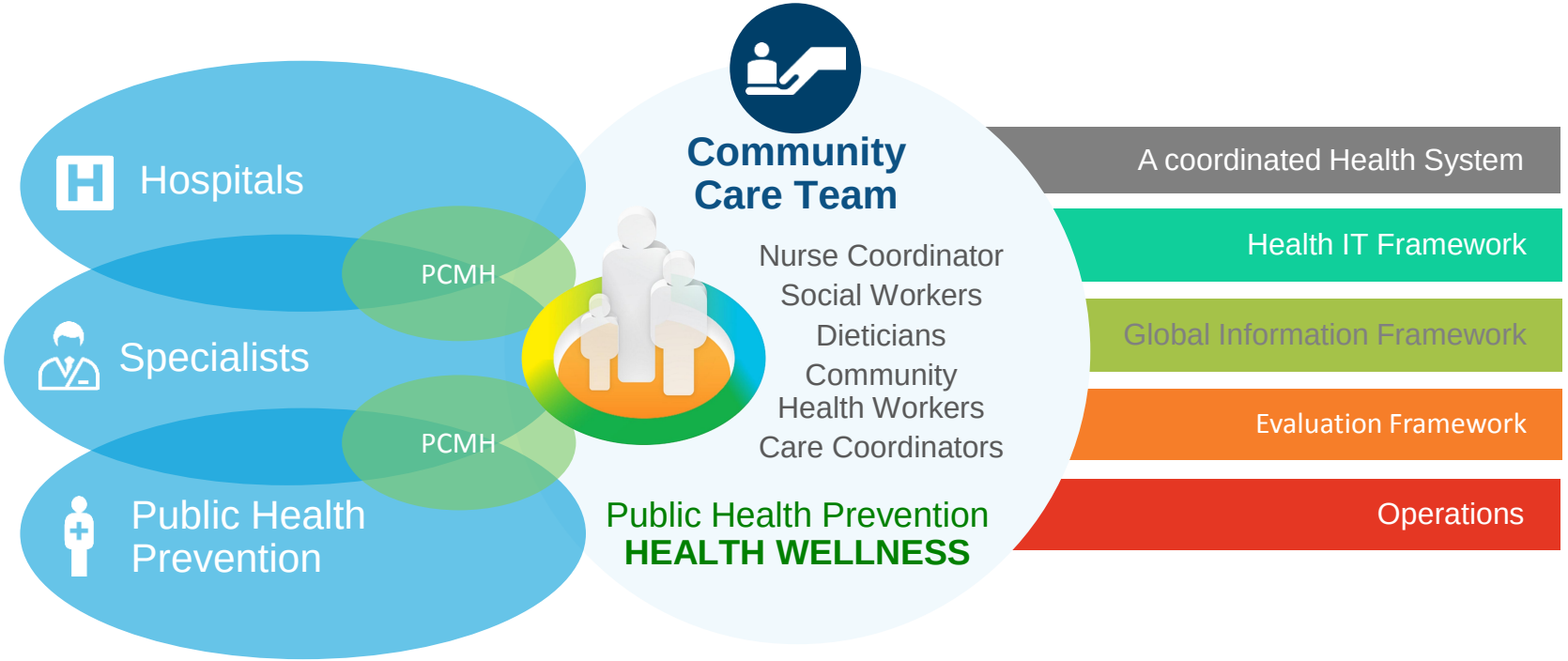
- Superb access to care
- Patient engagement in care
- Clinical information systems, registry
- Care coordination

- Team care
- Communication/ Patient Feedback
- Mobile – easy to use and available information

Benefit redesign – Patient engagement
Different strategies for different Healthcare spend segments



PCMH 2.0 in action



Jersey Post

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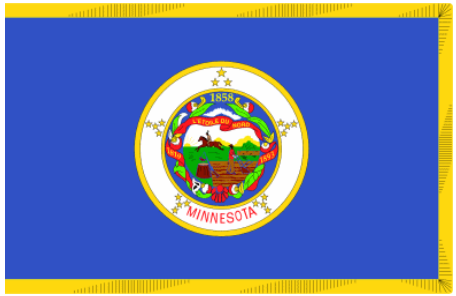
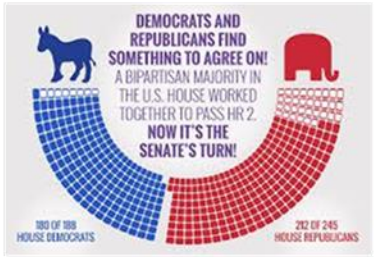
Call & Check Providing support and care for all in the community

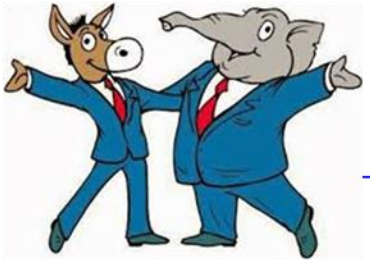
Maryland – NEJM Nov 2015





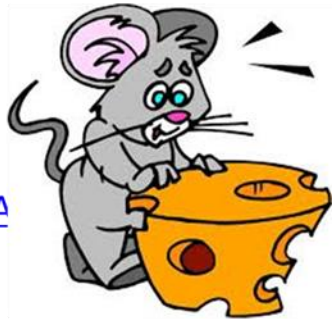
Nearly 1/3 traditional Medicare tied to alternative reimbursement models—such as Patient Centered Medical home (PCMH)/ accountable care organizations (ACOs) or bundled payments—by the end of 2016 --- 50% by end 2018

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