Engaging Providers with Payers to Revolutionize Healthcare Delivery
August 10th 2017
Objectives

• Describe Patient Centered Medical Home standards and impact PCMH has on cost and quality of care
• Discuss practice transformation and benefits of PCMH from a physician perspective
Have you ever felt like this?
Why is transformation needed?

• It would require an 18-hour work day for a primary care provider to manage the recommended preventive, chronic and urgent care needs of their patient panel (Bodenheimer, 780)

• 55% of all medical office visits are for primary care but only 4-7% of health care dollars are spent on primary care (Buelt, 6)

• The US health care system is the most expensive in the world, but is last or near last on dimensions of access, efficiency, and equity (Davis, 1)
Frustrated care team
Stressed with load & inefficient processes

Patients readmitted to hospital due to medication error after discharge

Patients with chronic illness poorly managed

Missed diagnosis such as depression, anxiety concerns

Episodic Care
Healthcare system focus on acute & illness

No follow up

Fragmented care
No appointment coordination, no access to care, different providers, no communication

Patients confused by instructions from provider, so they don’t follow them

Overuse of testing from no communication from Providers
What if we can’t do it all?

• The Medical Home Philosophy uses: “It takes a team”... ("Patient Centered Primary Care Collaborative," 2)
  ▪ Patient-centered
  ▪ Comprehensive
  ▪ Team-based
  ▪ Coordinated
  ▪ Access-oriented
  ▪ Focuses on quality and safety
Patient/family needs come first

**Quality of Care improved**
Focus on continuous improvement for quality and safety

**Care is Coordinated**
Care management support for those with higher health needs/ Transition of care and referral tracking

**Comprehensive care**
Primary prevention to include screenings and preventive care as well as chronic disease management

**Team Based care:**
Relationships with primary care team.

**Access to primary care team when needed**
Same day/next day appts. for routine or urgent care needs, relationship with care team
Phone/electronic access

**Improved experience for patient & care team**
Affects of PCMH on cost and efficiency

Lower utilization and overall cost reduction

- **11%** lower use of ER
- **12%** fewer hospitalizations
- **15%** lower overall cost per Member attributed to a PCMH
Who benefits from PCMH

• PCMH started in Pediatrics with high risk children
• More recently Medicare and Medicaid demonstration projects showing improved quality outcomes in Chronic disease management
• VHA health system found lower use of ER, urgent care, hospitalizations, and lower use of specialty services for mental health conditions
• PCMH projects from Health plans showing improved quality and reduced cost
What do I do first?

**PCMH Standard 1**: Team Based Care and Practice Organization

- Leadership team including Physician champion
- Establish roles for clinical teams
- Establish communication for team (Huddles)
- Evaluate processes and policies according to PCMH standards
Physician and Team engagement

• Education and involvement on process changes
• Work with highly engaged teams first to demonstrate success
• Competition with transparency data
• Physician to physician discussion
• Payment incentives
PCMH Standard 2: Knowing and Managing your patients

- Identify reports in your EMR that can capture high risk population and may use registry reports from payers
- Screening for high risk conditions ie: Depression, substance abuse
- Evidenced based clinical support
Access and Continuity

**PCMH Standard 3: Patient Centered Access and Continuity**

- Identifying a primary care team and establish relationships
- Access to care for routine and urgent care needs
- Provides timely advise by phone or Electronic media
PCMH Standard 4: Identifying patients for care management

- Identify patients through EMR report or reports from health plans and or other outside resources those patients who may be higher risk due to poorly controlled chronic health conditions, behavioral health needs, social determinants of health
- Establish care plan for those patients
**PCMH Standard 5:** The practice systematically tracks test results, referrals and care transitions

- Having a process for watch for test results
- Referral tracking, making sure that information is coordinated between providers
- Discharge from hospital and ER follow up
Quality Improvement

**PCMH Standard 6:** The practice establishes a culture of data-driven performance improvement on clinical quality, patient experience and involves staff and patients

- Measuring quality and setting goals for improvement
- Involving patients in quality improvement - eye opening sometimes
- Transparency in reporting quality data helps build engagement among providers
Stopping the primary care crisis ...

- PCMH care models engage the team and patients to improve their health
- PCMH care model showing total reduction in cost and improvement in patient and provider satisfaction
- Collaborative partnerships that support primary care are key to building a sustainable system that supports primary care
Questions

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Ian Randall, PhD; Charles Maynard, PhD; Beth Devine, PhD and Chris Johnson, PhD,” Assessing the affect of VHA PCMH model on utilization patterns among Veterans with PTSD” American Journal of Managed Care. Vol.23.No5


NCQA PCMH standards 2017. “Getting started with NCQA Patient Centered Medical Home Recognition, [www.ncqa.org](http://www.ncqa.org)