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Medical Home NEWS

Bundles: The Risk of Underestimating Primary Care

By Thomas R. Graf, MD, Melissa McCain, and Cynthia Bailey

Bundled payment arrangements are quickly becoming a reality for many provider organizations. Health system leaders are responding to both government mandates and commercial payer initiatives with a variety of improvement programs designed to demonstrate required performance levels in quality, patient experience and cost. Achieving these targets will depend on the system's ability to impact both clinical outcomes and total cost of care across the continuum – a goal only possible with the full involvement and integration of primary care.

Primary care plays a critical role in the health system's ultimate success or failure with bundled payments -- and ultimately, the success of any medical homes initiative.

In most bundles, primary care providers (PCPs) manage the majority of the days of a 90-day episode - and the associated controllable costs - and are ideally positioned to improve the pre- and post- procedural care that impact complication and readmission rates, care outcomes and total cost of care. Improvement initiatives risk failure if they are too "hospital-centric" in their approach - focusing only on hospital-based specialties and inpatient programs, without recognizing the importance of fully engaging primary care in the effort.

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In This Issue

What is a Medical Home?

By Carol Marak

If you ask seniors and family caregivers what is a "medical home," what would they say? Research marketers and industry focus groups find that consumers think it has something to do with long term care vs. a high-quality primary care practice. To some extent, they are correct, but in reality, it is a team-based health care delivery model led by a health care provider. It's designed to deliver comprehensive and continuous medical care to patients with the goal of obtaining maximized outcomes.

I work with Aging Council members at Seniorcare.com; the professionals who dedicate a lot of their effort helping seniors receive the best care possible. They're exposed to the various misunderstandings that consumers have on all sorts of senior-related topics, but the ones about health care seems to carry the most confusion. Speaking to the aging experts, here are some of the false impressions consumers have about medical homes:

It's a Nursing Home

Shannon Martin of Aging Wisely believes many elders think a medical home means it is a nursing home. It's not common terminology outside the medical community.

Anthony Cirillo at The Aging Experience says that consumers confuse it with a nursing home. It is a wrong choice of words. It conveys no sense of what it is regarding how the model approaches health holistically (that is, when done right).

Rhonda Caudell, Endless Legacy, agrees that consumers would say a "nursing home" or it is a nursing home located on a floor or wing of a hospital.

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Editor's Corner

Editor, *Medical Home News*

We continue our op-eds with an article from Kristin Stitt on the means to achieving proper care coordination.

Kristin Stitt, DNP
Consultant
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Care Coordination: Our Best Hope for Achieving the Triple Aim

Healthcare spending in the United States now totals $2.5 trillion a year, the most per capita in the world. Unfortunately, the amount of money spent does not translate into better care, with Americans having poorer health outcomes than other first-world countries.

Care management software sits at an important intersection of patient, community, and health system. Research and experience have resulted in an evolution of thoughts about improving health outcomes, and the patient has continued to be at the center of change.

Healthcare outcomes are driven by multiple factors. The quality of the care delivered, including the utilization of evidence versus intuition, the accessibility of care, and the affordability of care are just a few. Probably the most important element, however, is the patient, and the accompanying myriad of behavioral, environmental, and psychosocial factors that make each of us individually unique.

Hypotheses now abound that patient-centered, evidence-based care is one of the elemental components of health reform. However, consistently defining, and more importantly, operationalizing the concept in daily care delivery is challenging. The historic "one-size-fits-all, top-down-authoritarian approach" to patient behavior modification has historically been ineffective, and is the antithesis of the now globally recognized term "patient-centered care".

In fact, the World Health Organization says that approximately 70 percent of health outcomes are related to these factors. Until we can influence, understand, and change behavior based on modification of these factors, our costly healthcare efforts will continue to be suboptimal. Understanding the patient contributions (or lack thereof) in achieving evidence-based practice is imperative if we are to pursue an ever-increasing accountability for healthcare outcomes.

This is not a feat for the faint-hearted. Changing behavior is difficult. This difficulty is compounded by the time constraints encountered in the current care delivery system. To effectively assess and alter behavior, health systems will have to find mechanisms to identify, stratify, engage, modify, and measure a patient's individual characteristics and ensuing behavior as related to health outcomes — all, of course, in the context of being efficient and cost-conscious.

The most promising method to achieve this is via care coordination supported by software specifically built for the task. Coordinated care has been deemed the hallmark of a successful and caring health system, yet quality assessment in this field has lacked actionable, outcome-focused measures.

With the accelerated migration to outcomes-based reimbursement, successful health care systems will need to fully understand how to manage an individual patient's health and healthcare across the care continuum, engaging the patient as an active, accountable participant in the process. Without an engaged patient, failure is all but guaranteed.

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Medical Homes Can Lead To Cost Savings Among Commercially Insured

But Geisinger Study Concludes Those Reductions Are Relatively Modest

By Ron Shinkman

The clinical performance of patient-centered medical homes have been widely chronicled by numerous studies and white papers. But what about their ability to cut costs?

That was something that researchers at Geisinger Health in Pennsylvania decided to put into concrete numbers with a study recently published in the journal *Risk Management and Healthcare Policy*. It examined claims data of its health plan population between 2008 and 2013 for the study. Claims were specific to Geisinger Health Plan's ProvenHealth Navigator patient-centered medical home. During that period, Geisinger set up 95 sites devoted to patient-centered medical homes.

Their conclusions: A patient-centered medical home can cut costs if properly deployed and managed. However, dramatic reductions in a commercially insured population should not be expected.

Cost Savings For Geisinger Medical Homes Program

Months In Medical Home	Total Observed Per Member Per Month Costs	Total Expected Per Member Per Month Costs	Difference	Percentage Difference
1–6	$235.00	$235.00	0	–
7–12	$225.00	$248.00	-23	-9.3
13–18	$226.00	$257.00	-31	-12.1
19–24	$214.00	$254.00	-40	-15.7
25–30	$230.00	$263.00	-33	-12.6
31–36	$227.00	$270.00	-43	-15.9
37–42	$212.00	$269.00	-57	-21.1
43–48	$215.00	$263.00	-48	-18.2
Greater Than 48	$211.00	$263.00	-51	-19.6

Altogether, the greatest cost savings were after patients had been lodged in the medical home after 36 months. Between 37 months and 42 months, the regression adjusted cost of care on a per member per month basis dropped by about 21.1%, or $57. That includes not only claims payments made to providers, but the enrollee's out-of-pocket costs. However, that savings dropped off after that time period, and there was a gradual ramp-up prior to that. The mean time of participation for each health plan enrollee was 21 months. And the overall average cost savings after the first six months of participation was 9.1 percent, or just $22 per member per month.

“The savings seem to be modest compared to the overall cost of care,” said Daniel Dukjae Maeng, a research investigator at the Geisinger Center for Health Research and the study's lead author.

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Medical Homes Can Lead To Cost Savings *...continued from page 3*

That's in part because the population included in the study are enrollees in Geisinger's commercial health plan and are significantly healthier than those in a Medicare population. The mean age of the medical home enrollees is less than 43 years; only a small number of them have chronic conditions such as diabetes or kidney disease. Much of the cost savings was achieved by focusing on outpatient care.

"A lot of the care for this population is episodic as opposed to chronic," said Joann Sciandra, associate vice president of population management at Geisinger Health Plan. "We went after them with tools to manage their conditions, keep them out of the ER, and make sure they have ongoing access to care."

The study's conclusion was fairly clear: "(it) provides another piece of evidence supporting the hypothesis that PCMH can lead to lower cost of care." But that is not their primary objective, according to Maenge.

The Demographics Of The Geisinger Health Plan Medical Home Members In The Study

Mean medical home exposure length (months): 21
Total number of site–month observations: 2,670
Mean number of members per site per month: 595
Mean member age (years): 42.7
Mean proportion of females: 51.2%
Mean proportion of members with Geisinger Health Plan Rx coverage: 85.5%

Chronic conditions

Mean proportion of members with chronic kidney disease: 0.67%
Mean proportion of members with end-stage renal disease: 0.08%
Mean proportion of members with diabetes: 7.5%
Mean proportion of members with asthma: 7.5%
Mean proportion of members with congestive heart failure: 0.53%
Mean proportion of members with COPD: 1.4%
Mean proportion of members with coronary artery disease: 3.1%
Mean proportion of members with hypertension: 20.1%
Mean proportion of members with cancer: 2.6%
Mean proportion of members with depression: 7.7%

Medical homes are not about primarily cost reduction," he said. "It was never intended to be a cost-savings strategy on its own."

Bundles: The Risk of Underestimating Primary Care *...continued from page 1*

PCPs must take a proactive approach to engaging and educating health system leadership regarding the valuable role of primary care in achieving the improved clinical and financial outcomes required in this rapidly expanding bundled payment environment.

The New World of Bundled Payments. The Centers for Medicare & Medicaid Services (CMS) has recently made bold moves toward expanding the use of bundled payments through the Bundled Payment for Care Improvement (BPCI) and the Comprehensive Care for Joint Replacement (CJR) programs. These are likely just the beginning; CMS is expected to continue expansion to additional geographic areas and episodes of care as it transitions to its stated goal of 50% value-based care by 2018. Many commercial insurers are following CMS' lead, with a range of bundled payment contracts already in process.

Bundled payment arrangements have significant clinical, operational and financial implications for health systems. As they take on increasing accountability, system leaders are challenged to develop effective strategies for improving the quality and cost of care across the continuum.

- ***The Bundled Payment for Care Improvement (BPCI)*** *program includes 48 episode types and currently has more than 1,600 participants, including 415 acute care hospitals, 305 physician groups and 723 skilled-nursing facilities (SNFs).*
- ***The Comprehensive Care for Joint Replacement (CJR)****, beginning April 1, 2016, will initially include 789 hospital participants in 67 metropolitan statistical areas (MSAs) and will cover the full hip and knee replacement care episode, including patient recovery up to 90 days following surgery.*[1]

Because most bundles are triggered by an acute care episode, improvement initiatives have typically focused on managing procedures, with the involvement of procedural specialists and to some extent hospitalists. Improvement teams are often organized around areas such as care process standardization to reduce treatment variation; cost management, including supplies and utilization of diagnostic testing; inpatient case management; and targeted readmission work. While these can be areas of significant opportunity, health system leadership must avoid being too inpatient-focused, as much of the ultimate improvement opportunity –in both quality and costs- exists outside the procedure itself. Effective control of existing conditions including blood sugar, blood pressure, or heart failure *prior* to the procedure significantly impacts post-procedure outcomes including complications and readmissions.

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Post-acute care is a major component of total per-episode spending; of the episodes CMS proposed, post-acute care accounted for 30-70 percent of costs. For example, post-acute care and readmissions account for nearly 40 percent of Medicare spending for 30-day CHF episodes, and 37 percent of spending for joint replacement episodes [2] Improvement in pre-admission and post-acute care management is essential to achieving quality and cost goals – areas that primary care is uniquely positioned to impact. A health system's ability to succeed with bundles will depend on leadership's recognition of primary care's critical role in managing care outcomes and total cost of care across the continuum. This may represent a shift in approach for some organizations that are accustomed to prioritizing the role of procedural specialties in improvement efforts, but will prove beneficial to successful positioning for bundles and other value-based arrangements.

Leveraging Primary Care for Bundled Payment Success. As health system leaders organize improvement initiatives and teams, they should include all providers in a position to impact total cost of care and ultimate care outcomes. High performing primary care providers are ideally positioned to impact a number of key areas:

1. ***Patient Identification and Selection***: Because of their familiarity and understanding of their patients' current health status, health history, underlying conditions, family/ social support and stresses, reliability regarding care plans and medication, etc., primary care providers are well-positioned to assess the appropriateness of the patient for a particular procedure, signaling if a patient is too sick and at risk for a poor clinical outcome. Optimal matching of patient and procedure will result in the best outcomes and maximal health improvement. Additionally, appropriate timing and sequencing of the episode within the context of the patient's overall medical situation is critical to best outcomes.
2. ***Patient Preparation***: PCPs play an essential role in ensuring that patients are optimally prepared prior to a procedure / hospitalization. Patients who are part of a high-performing medical home and receive consistent and effective preventive, consultative, and treatment services, are likely to have well-managed health conditions. When emergent conditions arise, these patients are prepared physically and emotionally. Procedural outcomes, including complications and readmissions, depend greatly on the effective management of a patient's underlying condition (e.g., diabetes or heart failure). For example, a patient admitted for a hip replacement may face unexpected complications if his heart disease is not adequately controlled prior to surgery.
3. ***Transition Management***: As patients transition from outpatient to hospital settings, and then to post-acute facilities or home, it is extremely important that evidence- based protocols appropriately tailored to individual needs are extended across the continuum, that care plans and all pertinent health information are effectively communicated and actively and continuously shared, and that the patient and family are active team members in the care process. PCPs are ideally positioned to ensure smooth and effective transitions between the outpatient, inpatient and post-acute teams through timely, relevant information-sharing, communication, and coordination, all of which may lead to better clinical and financial outcomes for the patient and the health system.
4. **Post-Acute Care Management**: Strong connections between primary care and post-acute facilities support optimal post-acute placement and ongoing patient management. A post-acute facility with daily on-site clinician presence, for example, allows for placement of a broader range of patients and more rapid treatment of emerging exacerbations. When PCPs are able to closely follow patients in the post-acute setting, earlier discharge or discharge to home directly is more likely possible. Additionally, close post-acute monitoring by PCPs can minimize ED visits and readmissions. With effective follow up, PCPs can ensure that the patient has appropriate rescue plans, all needed medications, all relevant information, and that any emerging exacerbations and other complications are quickly identified and aggressively managed throughout the long period of chronic disease stabilization required to successfully complete a 90 day episode.

An Opportunity for Primary Care: Taking Action. For high-performing primary care providers, bundled payment programs represent an opportunity to become more fully involved and integrated in health system performance management and improvement. While initial efforts may be focused on reducing inpatient procedure costs and specialty treatment variation, health system leaders are increasingly recognizing the value of pre- and post- procedural management – an area where primary care plays a significant role. PCPs should proactively demonstrate to the broader system how greater primary care involvement in the management of bundles will lead to improved clinical and financial outcomes. A specific action plan, with detailed worksteps, timeframes and accountabilities, can help primary care groups to develop and communicate an effective case to health system leadership and secure their place at the table. Key steps include:

1. ***Make sure your own house is in order***. As you are advocating for a greater role in the system, make sure your primary care network is the right size, structure and design, and has the right mix of providers so that you can follow through effectively. It will be important that primary care speak with a single, coordinated voice; all providers must be aligned with the overall vision, goals and tactics of the effort and be adequately connected with each other to work as an effective team. Leadership will need to see that primary care is ready and able to coalesce around a process to develop solutions relevant to bundles.
2. ***Build linkages with specialists and post-acute providers***. Primary care has an important role to play as coordinator and integrator of different bundles across specialties and the full continuum of care. Building effective working relationships with specialists and post-acute providers is essential to improved management of pre- and post-procedural care; these connections are increasingly important in a value-based environment.

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3. ***Arm yourself with data and create a compelling case***. The ability to demonstrate potential clinical and financial improvement through greater involvement of primary care in bundle management will go a long way toward capturing leadership's attention and interest. Come ready with relevant statistics and information, such as:
   - Number of hospital patients your PCP group is currently managing
   - Major causes of readmission for primary DRGs
   - Demonstrated success in managing chronic disease exacerbations and avoiding emergency department and inpatient utilization
   - Dollar amount of financial risk associated with post-acute
   - Evidence of ability to effectively manage post-acute transitions either to facilities or directly to home.
   - Improved chronic disease outcomes through optimized control and preparation for planned procedures

Use data and specific examples to show how the involvement of your group will impact clinical and financial outcomes. Communicate your case for greater involvement clearly and simply, in a manner your colleagues can understand.

"For high-performing primary care providers, bundled payment programs represent an opportunity to become more fully involved and integrated in health system performance management and improvement. While initial efforts may be focused on reducing inpatient procedure costs and specialty treatment variation, health system leaders are increasingly recognizing the value of pre- and post- procedural management – an area where primary care plays a significant role."

4. ***Develop an integration team***. Frequent collaborative work sessions / meetings that include active data sharing, performance management, and protocol integration will be required. Team members should be encouraged to share their diverse skillsets and perspectives. Success will depend on the ability to translate data into meaningful, actionable information that supports and demonstrates achievement of superior clinical and financial outcomes.

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What is a Medical Home?…*continued from page 1*

Shelley Webb with Transitional Caregiver says rather than a team-based health care delivery model that is patient-centered health care, many seniors still recall Grandma placed into a nursing type facility. It's easy to understand their confusion.

It's Like a Hospital

Scot Cheben at Caregiving Answers believes people have never heard the term and thinks it is a transition house or something between nursing home and a hospital. Some believe it is a new program that provides services to a skilled nursing facility. After explaining to them what a medical home is, they say they never heard of it but believe it's a good idea.

A Specialized Facility

Caryn Isaacs at Get Health Help says people believe it is a "home" equipped with medical devices and equipment such as stair lifts, hospital beds or oxygen.

Stephen D. Forman, CLTC, Long Term Care Associates, Inc.. agrees, no matter what survey respondents say, I wouldn't read too much into it. A recent study found that most Americans could not define long-standing terms like "co-pay" or "deductible" so is it fair to expect few people to know the dozens of new terms birthed by the Affordable Care Act? From Person-Centered Care to Accountable Care Organizations, from IPAB to VBP, it's a whole new world!

Evan Farr, Farr Law Firm, thinks seniors may confuse "medical homes" and "nursing homes," but, they are far from the same thing. Medical homes themselves differ from one another, adding to the confusion. For instance, not all medical homes look alike or use the same strategies to reduce costs, improve quality, or coordinate care. Also, a medical home can be either a physical or virtual network of providers and services.

"Medical homes themselves differ from one another, adding to the confusion. For instance, not all medical homes look alike or use the same strategies to reduce costs, improve quality, or coordinate care. Also, a medical home can be either a physical or virtual network of providers and services."

Ben Mandelbaum with Senior-Planning believes seniors say it is a place to receive long-term, end-of-life care. The patient-centered model of medical homes, however, offers comprehensive, coordinated care that is designed to provide for a patient's preventative and primary medical care needs. Patients are also able to acquire services quickly and at odd times.

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What is a Medical Home?…*continued from page 6*

Thanks to the Aging Council, we got a clear image of the misconceptions and can understand what medical homes are not. In 1967, the American Academy of Pediatrics introduced the concept with the intent to centralize a patient's medical records. At the time, the care of children with special health care needs was the primary focus of the model. However over time, it evolved to imitate the evolving needs and perspectives in health care.

The features of a medical home include crucial values -- it's about the care given:

- Personal physician—each person has a personal physician trained to provide continuous and comprehensive care.
- Physician directed medical practice—the doctor heads up a team at the practice level who take care of patients.
- Whole person coordination—the care plan falls in the hands of the physician and arranges all the care a patient requires, including acute care; chronic care; preventive services; and end of life care.
- Integrated care across all elements like hospitals, home health agencies, and nursing homes within the person's community. The coordinated care includes registries, information technology, and health information exchange to make sure patients get what they need.
- Medical homes or Practices advocate optimal, patient-centered outcomes driven by a compassionate collaboration between physicians, patients, and the patient's family.

I don't know why it's called medical "home," it's more like a medical "team" involving physicians, family caregivers, and patients.

Carol Marak may be reached at Carol@seniorcare.com.

Care Coordination: Our Best Hope for Achieving the Triple Aim…*continued from page 2*

The care plan serves as the dynamic blueprint to guide this complex process. A robust care plan incorporates a person's medical and psychosocial needs, evidence-based interventions to address those needs, and a person's individual preferences and values regarding the goals of proposed treatment plans. It captures the process designed to meet those goals, and assigns accountability along the way.

"The historic 'one-size-fits-all, top-down-authoritarian approach' to patient behavior modification has historically been ineffective, and is the antithesis of the now globally recognized term 'patient-centered care.'"

For successful care coordination platforms, it includes assessing a patient's readiness to change, monitoring and measuring a patient's response to evidence-based treatment, and identifying in real time where break-downs occur. By sharing this information with all members of a care team, a synchronized and organized delivery of evidence-based, patient-centered care is possible.

Robust care coordination software solutions have the potential to become the platform to extend and operationalize evidence based care…from the point of care to a defined patient outcome, capturing not only the treatment plans initiated, but the individual patient choice and response, modifications to accommodate for both factors, and progress toward mutually established goals.

Ultimately, the ability to translate evidence into practice, monitor the practice, and adapt on an individual basis to achieve a defined outcome, will drive improvement in health and healthcare.

Kristin Stitt, DNP recently completed a Doctorate of Nursing Practice in Systems Management at Vanderbilt University, focusing on the utilization of system data and clinical evidence to concurrently guide administrative and clinical decision making in ACO population health initiatives. She may be reached at kristin.stitt@roundingwell.com.

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We encourage you to contact us any time with feedback of any kind regarding *Medical Home News*. We especially would like to hear from you regarding what topics you'd like to see addressed in future issues.

Thought Leaders' Corner

Each month, *Medical Home News* asks a panel of industry experts to discuss a topic of interest to the medical home community. To suggest a topic, write to *Medical Home News* Editor Ron Shinkman at RonShinkman@gmail.com.

Q. What do you think are the current components of a successful patient-centered medical home?

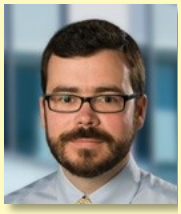
"A fundamental attribute of a successful patient–centered medical home would its contribution to improving patient access to medical care, by involving a team of healthcare providers (nurse practitioners, physician assistants, nurses, care managers, pharmacists, dietitian, social workers, educators, etc.), led by a physician. When specialized care is needed, it is either integrated into the practice or transitions in care are coordinated fully by the medical home. A successful patient-centered medical home also utilizes evidence based practice and involves patients in choosing their own medical options and supports patients in managing their own health. It creates strong, trusted relationships between the patients and the healthcare providers through clear and open communications, meeting the unique needs of each individual patient. The practice consistently measures and responds to the patents experience and continually works to improve outcomes."

Lisa Simm
Risk Manager
Coverys
Boston, MA

"You have to have strong team-based care. You can't have it all on the back of one person working with all the patients. There must be access. That's a key factor. When a patient calls in, there should be flexibility for same-day appointments. If they have a concern and call at 8 o'clock at night, they can't just get an answering service and a suggestion to go to the emergency room. The medical practice also has to partner with the patient, know them, and have access to their healthcare information so if there is an issue three states away, it can be shared with the other provider. There also has to be care coordination, which has not always been well-supported in practices. And then, the piece that has been hardest to tackle is the centrality of having the patient and their family or a good friend to be key partners in the care team. Obviously, with a young child, it will be the parent or the guardian, or it could be their neighbor."

Amy Gibson
Chief Operating Officer
Patient-Centered Primary Care Collaborative
Washington, DC

"I like to look at this in terms of nature and nurture. A well-functioning medical home is inherently receptive to the concept to begin with. Some individuals take to it really well, and others may resist it; you have to have people on board for it to work. Some medical homes are also more receptive to coaching (from consultants or collaborative organizations) to help practices transform and deliver better care – sort of like the technical assistance aspect. On the nurture side, providers should receive good clear data from the payers they're working with, such as being able to identify who are the frequent fliers to the hospital emergency room. It can be the difference between flying blind and having good eyesight."



Mark Friedberg, M.D.
Senior Natural Scientist/Director, RAND Corp.
Boston, MA

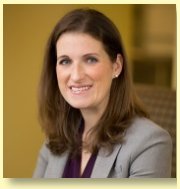
Thought Leaders' Corner

"There are a lot of definitions for a successful patient-centered medical home, but I believe the most significant component is based on the primary care physician. Each of our patient centers is predominantly staffed and run by primary care physicians and nurse practitioners, although there is also a core of specialists, along with laboratory and full imaging services. We call it 'healthcare under one roof.' One of the most important facets of this is accessibility. Our physicians have early morning, late evening and weekend hours to accommodate patients. Our goal is that any patient who wants to be seen that day will be seen. We now have a system of healthcare on demand, where patients want care when they want it, or it is convenient to their employment. We also provide patients with electronic accessibility, where they can contact the provider over the Internet, ask questions and receive responses electronically, or even request medication refills. That's really key in terms of taking care of patients and controlling their costs."

George E. Lowe, M.D.
Medical Director for Maryland Family Care
Baltimore, MD

"The patient-centered medical home has evolved over the past few years in response to the changing healthcare landscape, including patient demands, various market forces, and best practices defining more efficient and effective care delivery and operations. Moreover, the PCMH model has become more comprehensive to ensure high-quality coordinated care across the continuum. Core components support a strategy of patient-centered care, emphasizing population health and can be broken out into six key areas:

- **Patient/Caregiver Experience and Engagement** – creating a patient-centered model that is designed to support every aspect of a patient's care needs
- **Team-Based Care** – developing and assigning care teams to patients to allow for more comprehensive, coordinated care
- **Access and Continuity of Care, Services, and Information** – ensuring access across the continuum to care, services, and information
- **Care Management** – care management starts with identifying, understanding, and stratifying patient populations to assign appropriate care management services
- **Care Coordination and Collaboration** – processes, resources, and tools that enable care coordination and collaboration with a team-based model – between providers, patients, facilities, and the community
- **Measure, Track, and Report Clinical, Quality, Cost, and Utilization** – using claims and EMR data, to the extent possible, providers and organizations must have robust systems to measure, track, and report to support decision-making and ensure ongoing continuous improvement."



Emma Mandell Gray
Senior Manager
ECG Management Consultants

Industry News

MetroHealth

Ohio Insurer, Hospital System Team To Provide Medical Home-Anchored Insurance

Cleveland-based provider MetroHealth System and Medical Mutual of Ohio have joined forces to provide an insurance product for the medium and large group markets with premiums intended to be about 15 percent lower than current rates. CLECare, a full-risk HMO product, would be sold to employer groups with 51 or more employees.

"We take a care management approach, providing early interventions and preventive services, managing unnecessarily duplicative tests and complementing the program with interventions intended to overcome social barriers like transportation and nutrition," MetroHealth Chief Executive Officer Akram Boutros said of the patient-centric care that would be offered as part of the CLECare product. "We also sent a pharmacist to homes of patients using seven or more medications to insure their meds are in order," he said.

Industry News

Study: PCMHs Can Increase STI Vaccinations, Contraceptives For Adolescents, Young Women

Adolescents and young women who received their care through patient-centered medical homes were significantly more likely to receive contraceptives and screenings for sexually transmitted infections, according to a new study published in the journal *Pediatrics*.

Researchers studied 21,704 patients between the ages of 10 and 24 receiving care at clinics at the Hennepin County Medical Center in Minnesota. About 3 percent of this cohort, or 729 patients, were enrolled in one of the clinic network's 14 patient-centered medical homes. That group was more likely than the other patients to be Latino or African-American, and more likely to be enrolled in Medicaid, CHIP or another public health insurance plan.

Among that smaller group, they were less likely to receive preventative services such as flu shots (which often have a limited impact on that population anyway) but more likely to be screened for STIs and receive contraceptive services. They were about 1.5 times more likely to receive a vaccination for HPV, 1.7 times more likely to receive an STI screening, and more than twice as likely to receive a contraception prescription.

“Our findings support the usefulness of PCMHs as a healthcare strategy to increase the receipt of multiple preventive services in a health system that provides care to adolescents and young adults at risk for preventive care disparities,” the study's authors concluded.

Physician Organizations Urge CMS To Qualify Medical Homes For MACRA Payment Models

The American Association of Family Physicians (AAFP) and four other medical trade groups are pushing the Centers for Medicare & Medicaid Services (CMS) to include patient-centered medical homes among its new alternative payment models. The AAFP, along with the American College of Osteopathic Family Physicians, the American College of Osteopathic Internists, the American College of Physicians and the American Osteopathic Association, urged CMS acting Director Andrew Slavitt in an April 22 letter to consider medical homes as qualifying as an alternative payment model under the recently enacted Medicare Access and CHIP Reauthorization Act (MACRA).

“PCMHs are proven models developed in line with the Joint Principles of the PCMH supported by our respective organizations. Consensus and evidence has continued to build around the PCMH’s value in achieving improved care and better health at lower costs,” the letter said. “More than 90 health plans, 43 state Medicaid programs, multiple federal agencies, and thousands of clinical practices of varied sizes have adopted this model. As such, this model is proven and should be deemed as expanded...to meet the intent of MACRA and goals of the U.S. Department of Health and Human Services to move to value-based payments.”

Medical Homes Could Be A Good Way To Treat Gastric Disorders

A new proposal in the most recent issue of the journal *Inflammatory Bowel Diseases* suggests that patient-centered medical homes may be a sound approach toward treating Crohn's disease, ulcertaive colitis and other gastric disorders.

Such a home, rather than being anchored by primary care physicians, would be centered around gastroenterologists and related specialists. The article's lead author, Miguel D. Regueiro, M.D., a gastroenterologist at the University of Pittsburgh Medical Center, noted that “clinicians who care forthese patients recognize that this population requires specialized and personalized care. As with other chronic illnesses, certain individuals have higher rates of unplanned care; that is, they are frequent visitors to the emergency department or undergo more diagnostic testing. A subset of these patients with IBD are high utilizers of medical care.”

More than half of the patients treated for such disorders suffer from chronic pain, stress, anxiety and/or depression and fatigue. Such patients are at higher risk for an exacerbation of their symptoms and higher utilization of healthcare services.

A cohort of some 34 gastric disorder patients at the UPMC – out of 5,000 in total being treated through that healthcare system – have cost as much as $10 million to treat in a single year.

Under the proposal, such a medical home would include the patient's gastroenterologist, along with behavioral health professionals, nurses who serve as care coordinators, and a dietitian. Surgeon and pain specialists would be made available as needed.

Many such patients are treated with immunosuppressant medications, and care would center in part on a checklist that would monitor a patient taking such medications and their susceptibility to infections, osteoporosis, cancer and toxic levels of the drugs in their bloodstreams. Many patients are also susceptible to depression and other mental health disorders and would be closely monitored for symptoms as well.

Another locus of treating these patients are the use of opioids for pain management, which can lead to constipation and a worsening of their gastric symptoms. The article recommends weaning patients off of such medications and use a less damaging substitute, such as low doses of tricyclic antidepressants.

The article noted that the use of the medical home model for these patients in tiny pilot programs, led to “better adherence to medications and treatment plans, greater trust in their healthcare providers, reductions in unnecessary healthcare utilization, and overall improvements in patients’ quality of life.”

Catching Up With…*continued from page 12*

As a former Board member of the International Alliance of Patients' Organizations and a member of the Patient-Focused Medicine Development transatlantic collaboration between patient organizations and the biopharmaceutical industry, I am seeing the emergence of a global movement to incorporate the patient perspective in drug development. In some countries in Europe, we are seeing the movement spread to integrative health care delivery.

Medical Home News: *What kind of research is being implemented and discussed by the Patient-Centered Outcomes Research Institute (PCORI) in the area of patient engagement?*

Marc Boutin: The NHC championed for the creation of PCORI, and the patient community is involved in numerous ways at the Institute. For example, PCORI requires patient partners on all of its research projects, which was a first. PCORI also created the Patient Engagement Advisory Panel, of which I am a member. One of its chief accomplishments was creating a Patient Engagement Rubric, which provides all PCORI-funded researchers with a variety of methodologies for gathering input from patients, family caregivers, and patient organizations throughout the entire research process.

PCORI has already funded hundreds of research projects that address patient engagement. The NHC is a recent awardee, and we will be addressing methods for Increasing Patient-Community Capacity to Engage on Quality of Health Care Research and Programs. The patient community recognizes it needs to hone its capabilities to increase its currently limited ability to partner on quality-related, patient-centered outcomes, and comparative-effectiveness research.

This project will develop patient-specific training to increase the capacity of patients, advocacy organizations, and family caregivers to engage in patient-centered outcomes research where quality measures are a focus and where patient engagement is needed.

Medical Home News: *We are experimenting with a variety of value-based models of care – accountable care organizations, patient-centered medical homes, bundled payments, direct contracting, tiered networks, reference pricing – but you note that the patient perspective is rarely incorporated into their design. Can you briefly describe how your recently created National Health Council's Patient-Centered Value Model Rubric would help in this regard?*

Marc Boutin: Patient perspectives on value can differ significantly from that of physicians and payers, often integrating considerations beyond clinical outcomes and cost, such as a treatment's ability to help patients achieve personal goals. To have true utility, value models must incorporate these other influencing factors, and the only way to achieve this is by having robust processes in place to incorporate the patient voice. Such action is particularly important if physicians and payers look to value models to inform decisions that can affect the treatment options available to a patient.

The purpose of the NHC's Value Model Rubric (www.nationalhealthcouncil.org/value) is to help value-framework developers to meaningfully engage patients in the development of their value models and to promote patient centricity. To achieve true value in health, we need to move away from fee-for-service and beyond population health to models that align care with clinical outcomes that are relevant to patients, promote good health outcomes, and reduce overall costs. The NHC Value Model Rubric will help close the gap in our collective understanding about what outcomes are truly relevant to patients.

Medical Home News: *The recent proposed rule implementing MACRA contains incentives for providers who are more advanced in patient communication. What are the benefits and limits of financial incentives for providers in promoting patient engagement?*

Marc Boutin: The National Health Council has long advocated for shared decision-making between patients and their health care providers because patients have unique, individual, health and personal needs. However, the care they receive is often one-size-fits-all. What we advocate for is something we call the Chronic Care Trifecta. Under this approach, providers customize care based on three elements: a person's aspirations, life experiences, and preferred health outcomes. By ensuring that treatment plans respect all three elements, care is more relevant to an individual.

To achieve the Chronic Care Trifecta, we need to realign delivery system designs, quality measures, and payment models. Decades ago, our doctors were there when we were born, knew our family, and understood what was important to us. Our current system actively discourages care that is relevant to the individual while promoting noncompliance and non-adherence driving up costs to the system. We need to pay providers to build relationships with patients and their families, to engage in effective shared decision-making, and deliver care that helps patients achieve their goals in the context of their personal circumstances -- like doctors did decades ago. In emerging models being tested by the CMS Innovation Center we are seeing improved outcomes at reduced costs.

Medical Home News: *Finally, tell us something about yourself that few people would know.*

Marc Boutin: People within the health community are familiar with my long advocacy history working for various organizations in the U.S. that serve people with chronic conditions. What they probably don't know is that nearly every member of my immediate family has been diagnosed with a chronic condition, from the more common (cancer, heart disease, arthritis), to the more complex (multiple sclerosis, Parkinson's, lupus), to the rare (Pemphigus and Pemphigoid). I also have a sister who was born deaf. So for me, ensuring that people with chronic diseases and disabilities receive the care they deserve is a very personal goal.

Catching Up With …

Marc Boutin, JD is the chief executive officer of the National Health Council. He was appointed to the position in 2015 after a dozen years serving in increasingly greater positions of responsibility within the organization. He has been a leading voice for greater patient involvement at every stage of the healthcare continuum. He talks here about the National Health Council, patient engagement and value-based healthcare delivery.

Marc Boutin, JD

- Chief Executive Officer, National Health Council
- Member of the Patient-Centered Outcomes Research Institute (PCORI) Patient Engagement Advisory Panel, FasterCures Benefit-Risk Advisory Council, and MDIC Patient-Centered Benefit-Risk Steering Committee, Washington, DC
- Founding member of the international Patient-Focused Medicine Development consortium, Brussels, Belgium
- Served on the governing board of the International Alliance of Patients' Organizations, London, UK, as a member and treasurer.
- Served as vice president of government relations for the American Cancer Society, Washington, DC, prior to joining the National Health Council
- B.A., Aberystwyth University, International Politics/Law, Aberystwyth, Wales, United Kingdom; J.D., Suffolk University Law School, Boston

Medical Home News: *First, can you tell us a little about the work of the National Health Council?*

Marc Boutin: Founded in 1920, the National Health Council (NHC) is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the pharmaceutical, generic drug, insurance, medical device, and biotechnology industries.

We serve as an umbrella organization for patient advocacy organizations and work on a broad range of systemic health issues affecting people with chronic conditions. Our initiatives include influencing federal health care policy, advancing medical research and innovation, and enhancing patient access to quality care. We tackle each issue focusing on the needs of patients to ensure that all people with chronic diseases and disabilities receive the care they need to live longer and better lives.

Medical Home News: *You have extensive experience in patient engagement, both here in the U.S. and internationally. How does the U.S. healthcare system stack up against other industrialized counties in terms of patient-centered care and patient engagement?*

Marc Boutin: That was my intent. To the extent it succeeded, however, it certainly was not something I could have done alone. I told everyone they had three jobs -- – (1) to conduct the business of CMS in a way that set an example of excellence; (2) to serve as the lead agency for implementation of the Affordable Care Act and to do so through a regulatory process that was respectful and capable; and (3) to have CMS become an improvement organization that learns and leads. I described what I saw as a new vision for CMS -- – "to be a major force and trustworthy partner for the continual improvement of health and healthcare of all Americans." And based on quality management principles that we had practiced and taught at IHI, I proposed that we pursue that aim guided by five key operating values -–- boundarylessness, speed and agility, unconditional teamwork, innovation, and customer focus. It was gratifying to see that the vast majority of CMS staff were ready to embrace to those principles.

The U.S. healthcare system is evolving rapidly as a result of new technology and the emergence of consumerism in the health ecosystem. The Affordable Care Act includes numerous provisions that support value, shared decision-making, and individual care plans. The creation and implementation of the Patient Centered Outcomes Research Institute has revolutionized the concept of patient engagement in research. The Patient Focused Drug Development Program at the FDA has demonstrated that while the perspective of researchers, academics, and doctors is important, it cannot be a substitute for the patient perspective. Payers are looking beyond population health to new delivery models that promote clinical outcomes relevant to patients and their family caregivers. We are moving from good intentions to meaningful patient engagement, which is a critical first step in achieving patient centricity.

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