Patient-centered primary care homes

Better health, better care and lower costs

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Patient-centered primary care homes: good return on investment for employers

As the largest purchasers of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are implementing payment models that reward high value.

There is emerging evidence that patient-centered medical home programs (both nationally and in Oregon) are yielding a good return on investment for employers.[1,2] This brief provides more information about the patient-centered primary care home and highlights some of the early success of the medical home model in Oregon and in other national organizations.

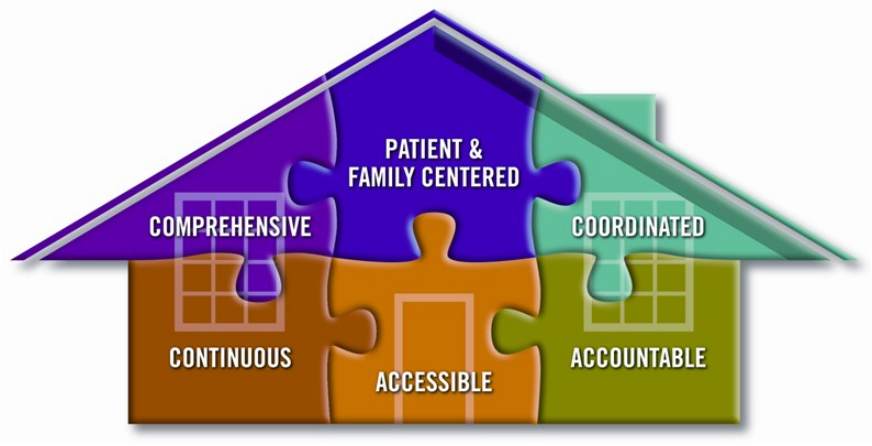
Benefits of a PCPCH

- Coordinated care to help employees get the services they need, when and where they need them
- Helps employees play an active part in their health
- Offers employees after-hours help and alternatives to the emergency room
- Drives down costs for employers by focusing on preventive care, wellness and managing chronic conditions

The Oregon way: patient-centered primary care homes (PCPCH)

A PCPCH is Oregon Health Authority's version of a "medical home," which is a primary care practice that gives patients the individualized care and support they need to stay healthy. In a medical home, the patient, the primary care physician, and a medical team work together to develop and implement a holistic plan of care for the patient. Primary care homes reduce costs and improve care by catching problems early, and focusing on prevention, wellness and management of chronic conditions. PCPCHs receive supplemental monthly payments on top of their traditional fee-for-service payment to provide this enhanced patient support.

Learn more about the PCPCH program at www.primarycarehome.oregon.gov.



Core Attributes of a patient-centered primary care home (PCPCH)

PCPCH core attributes

Accessible: Care is available when patients need it.

Accountable: Practices take responsibility for the population and community they serve and provide high-quality evidence-based care.

Comprehensive: Patients get the care, information and services they need to stay healthy.

Continuous: Providers know their patients and work with them to improve their health over time.

Coordinated: Care is integrated and the clinic helps patients navigate the health care system to get the care they need in a safe and timely way.

Patient- and family-centered: Individuals and families are the most important part of their practice. Care draws on a patient's strengths to set goals and communication is culturally competent and understandable for all.

Across the nation evidence is emerging that patient-centered medical home programs are yielding a good return on investment in terms of employer costs and patient outcomes. If you are interested in learning about national case studies of employers please see this article from the Robert Wood Johnson Foundation at http://www.bailit-health.com/articles/022613_bhp_paymentbrief_pcmh.pdf.

Case Study #1: Metropolitan Pediatrics

Metropolitan Pediatrics has four locations in the Portland Metropolitan area. It first was recognized as a medical home by the PCPCH Program in 2011. In 2015 all four practice locations achieved the new PCPCH 3 STAR criteria for the most advanced medical homes. By investing in robust population health management tools, Metropolitan Pediatrics gained a better understanding of their patients' needs. For example, they found that asthma was the most common chronic condition, and then implemented the latest evidence-based asthma care guidelines. They added RN complex care management and an immunization improvement program. Through these efforts, they achieved a 28 percent decrease in ED costs, lower inpatient and admission rates for their asthma patients, and immunization rates 22 percent higher than the rest of Oregon.

Metropolitan Pediatrics continues to expand their medical home model through integrated behavioral health clinicians, dieticians, a new and better-connected electronic health records system, annual patient surveys, the creation of parent advisory committees for community outreach and enhanced access to after-hours care. They have fully adopted a team-based approach to caring for children and families, and continuously push themselves to provide the best possible care. In 2016 they will lead advancement of Pediatric services in a new direction with the implementation of Adverse Childhood Experiences (ACES) Resiliency training to focus on appropriate care and support of childhood adverse events.

Case Study #2: Winding Waters Clinic in Enterprise, Oregon

Winding Waters began their transformation in 2009 when they became part of the Safety Net Medical Home Initiative—a national patient-centered medical home demonstration to help 65 primary care safety net sites become high-performing medical homes—improving quality, efficiency and the patient experience. Their first steps toward transformation included increasing access through open-access scheduling, expanded hours, and implementation of a team-based model of care.

As a result of these early transformation efforts, wait times for follow-up appointments dropped from 12 days in 2009 to same-day access in 2015. Wait times for refill requests dropped from five business days in 2009 to two hours in 2015. And average scheduling wait time for physicals dropped from 36 days in 2009 to three business days in 2015. Additional data collected from 2008 to the present show a clear reduction in hospital visits (for Winding Waters patients) and emergency room visits (for all of Wallowa County). Hospital visits declined by an average of 7.25 percent per year over a six-year period (32.5 percent total reduction in utilization since 2008). ER visits declined by an average of 6.4 percent per year over a six-year period (28.7 percent total reduction since 2008).

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How you can get started

1. Speak with your plan administrator about their experience with such programs. Most health insurers are now piloting or operating medical home programs.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group or health system that serves your population and ask about their experience with medical homes or PCPCHs, and their willingness to apply their program or develop a new one to serve your employees.
3. Participate in regional pilots.
4. Use a payment methodology that enhances payment to primary care practices.
5. Educate employees and dependents about the benefits of affiliating with and using a primary care provider.
6. Consider benefit modifications that provide incentives for use of a medical home.

Case Study #2: Winding Waters Clinic in Enterprise, Oregon (cont.)

These outcomes were achieved through use of an expanded team approach including care coordination, co-located and integrated behavioral health providers, and trained community health workers.

Winding Waters became a Tier 3 recognized Patient Centered Primary Care Home in 2012, and then became the first 3 STAR Patient Centered Primary Care Home in Oregon in June 2015. Winding Waters was awarded federally qualified health center status in August 2015, further ensuring sustainable service to the Wallowa County community.

Case Study #3: Michigan Demonstration Project to improve patient care

Through the Centers for Medicare and Medicaid Services, Michigan is one of eight states testing a patient-centered medical home across various payers, including employers and insurers. Nearly 1.8 million Michigan residents participate in this demonstration and receive coordinated, patient-centered care from physicians and health teams.

Primary care practices report improvements in the biggest health care challenges—obesity, diabetes, and hypertension. Adult patients in PCMH-designated practices had a 26 percent lower rate of hospital admissions for common conditions that could be addressed in a primary care setting.

Blue Cross-designated PCMH practices also had a 10.9 percent lower rate of adult emergency room visits and a 22.4 percent lower rate of pediatric emergency room visits for common chronic and acute conditions such as asthma. Blue Cross estimates that it has saved $512 million through disease prevention, reduced hospitalizations and emergency room visits, and management of acute and chronic medical conditions.

Improvements resulting from the PCPCH Program

Almost 600 primary care homes are recognized statewide, representing more than 50 percent of all eligible clinics in Oregon and serving over 2 million Oregonians, more than half of the state's population.

1. A 2013 survey of PCPCH recognized clinics found that 85 percent of practices feel that PCPCH model implementation is helping them improve the individual experience of care and 82 percent report the model is helping them improve population health management
2. Over time clinics recognized as PCPCHs showed a significant increase in preventive procedures and a significant reduction in specialty office visits as compared to non-PCPCH clinics.
3. In a recent report from the Oregon Health Care Quality Corporation that compared PCPCH recognized to non-recognized clinics, there were significant measure performance improvements in diabetes HbA1C and LDL-C; diabetes kidney tests; diabetes eye exams; adolescent well care visits; and Chlamydia screening. The report is available at: http://q-corp.org/sites/qcorp/files/qCorp-statewide-report-2015-postpress-corrected-singlepages_WEB-FINAL percent20BBF percent202.pdf.

Citations:

1. M. Nielsen, A. Gibson, L. Buelt, P. Grundy, K. Grumbach. The Patient-Centered Medical Home's Impact on Cost and Quality.
2. Oregon Health Authority. Patient-Centered Primary Care Home Program 2014-2015 Annual Report.