



***Central Ohio  
Patient-Centered  
Medical Home Project***

**Patient-Centered Primary Care  
Collaborative  
Center for Employer Engagement  
March 10, 2010**

**Coordinated by:**



**Lead Support**



**Major Support**



**Additional Support**



# *Overview of Presentation*

- ✓ *What is Access HealthColumbus?*
- ✓ *Why did we decide to advance patient-centered primary care in our community?*
- ✓ *What is our approach?*

# ***2010 – 2012 Strategic Plan***

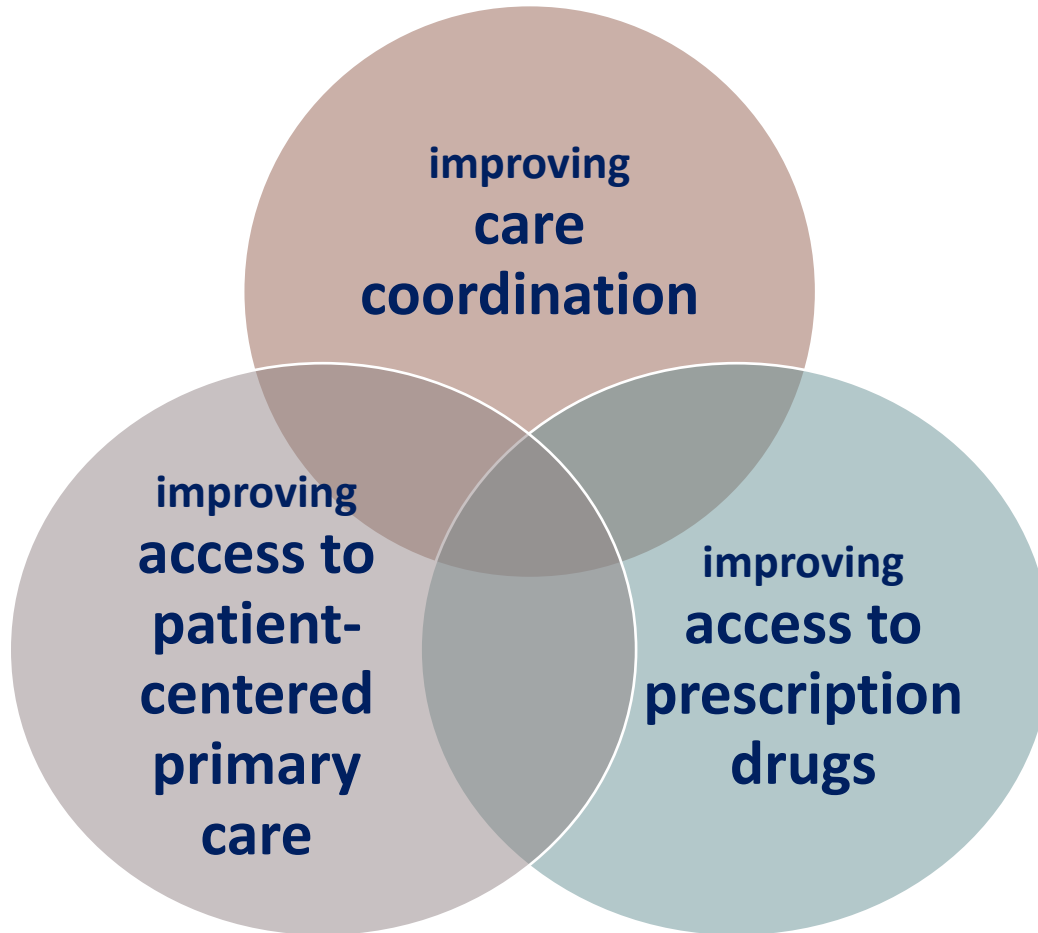
## **Our Mission**

**To improve access to health care in our community, particularly for those most vulnerable, by convening public-private partners and coordinating innovative solutions.**

## **Our Vision**

**Health care for all people that is affordable for individuals and sustainable for our community.**

# *Our 2010-2012 Strategic Areas of Focus*



**continuous commitment to...**

- ✓ **strategic planning**
- ✓ **evaluating, measuring and reporting results**
- ✓ **convening leaders from business, government, health care, insurers and consumers**

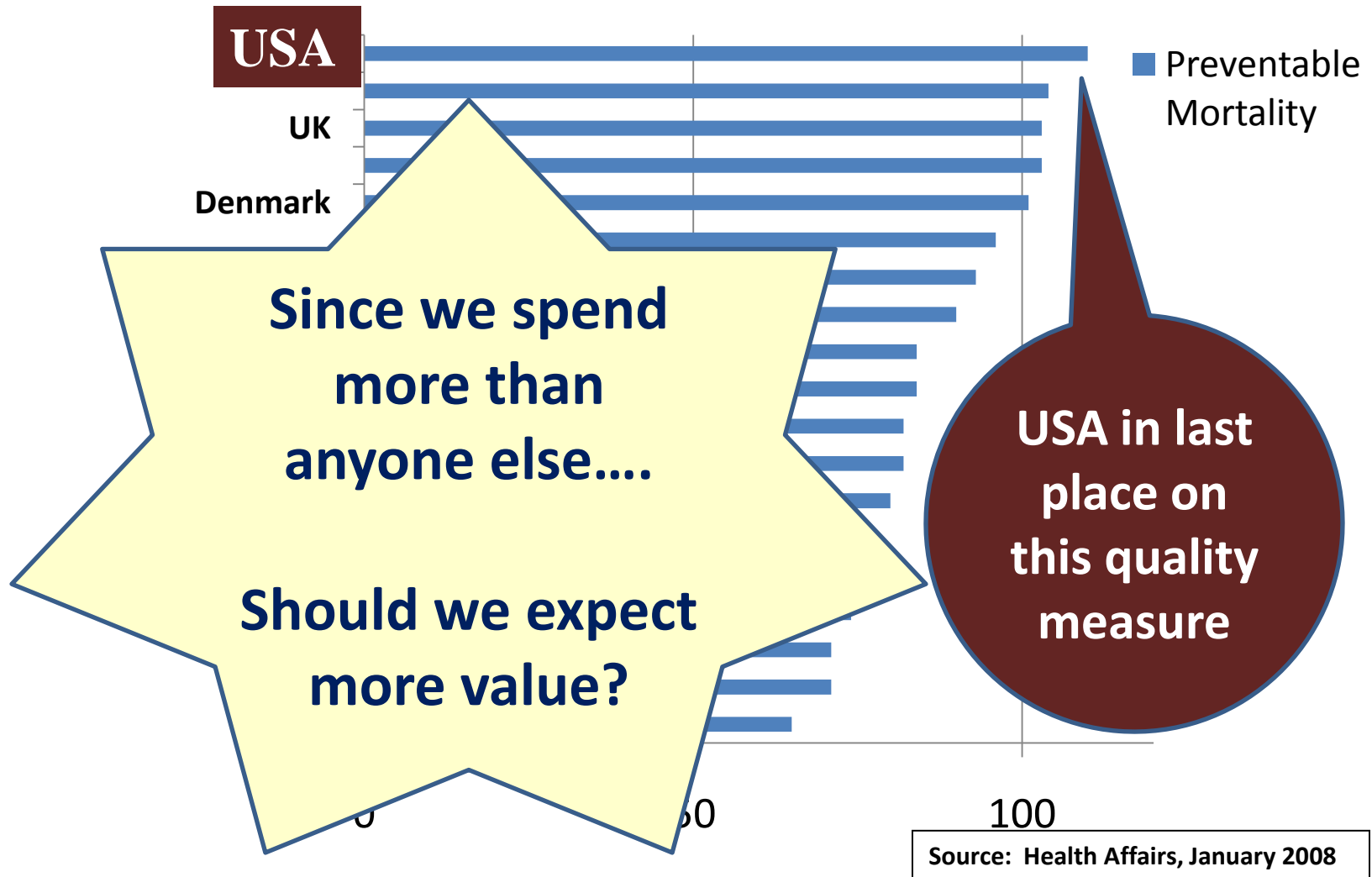
# *What are the major deficiencies in our current health care delivery system?*

- **Is not patient-centered**
- **Does not allocate adequate resources to support prevention and the improvement of health**
- **Does not clearly define patient and provider responsibilities**
- **Is not based on a foundation of partnerships between patients/providers/payors**



# Deaths that should not occur in the presence of effective health care

## Age-Standardized Death Rates (Per 100,000)



The fragmentation of our delivery system is a fundamental contributor to the poor overall performance of the U.S. health care system.

~ The Commonwealth Fund

*“Every system is perfectly designed to achieve the results it gets.”*

**Donald Berwick, M.D.**  
Institute for Healthcare Improvement (IHI)

# The current primary care system must be transformed to address current issues

## *Current challenges confronting primary care*

Emergency room visits increased by 36% between 1996 and 2006; 47% of ED visits could have occurred in a physician's office

20% of patients are readmitted within 30 days of hospitalization, most of which are avoidable

50% of patients that are readmitted do not see a physician after their first hospitalization

75% of health care spending is for patients with chronic diseases

Over two years, the typical Medicare patient sees 2 different primary care doctors and 5 different specialists

Millions of additional Americans will enter the primary care system with health reform

Advanced primary care models, like patient-centered medical homes, can provide the coordination mechanisms and decision support to improve quality, cost, and satisfaction

<http://blogs.wsj.com/health/2008/08/06/emergency-room-visits-hit-record-high/>

<http://www.medicalnewstoday.com/articles/157206.php>

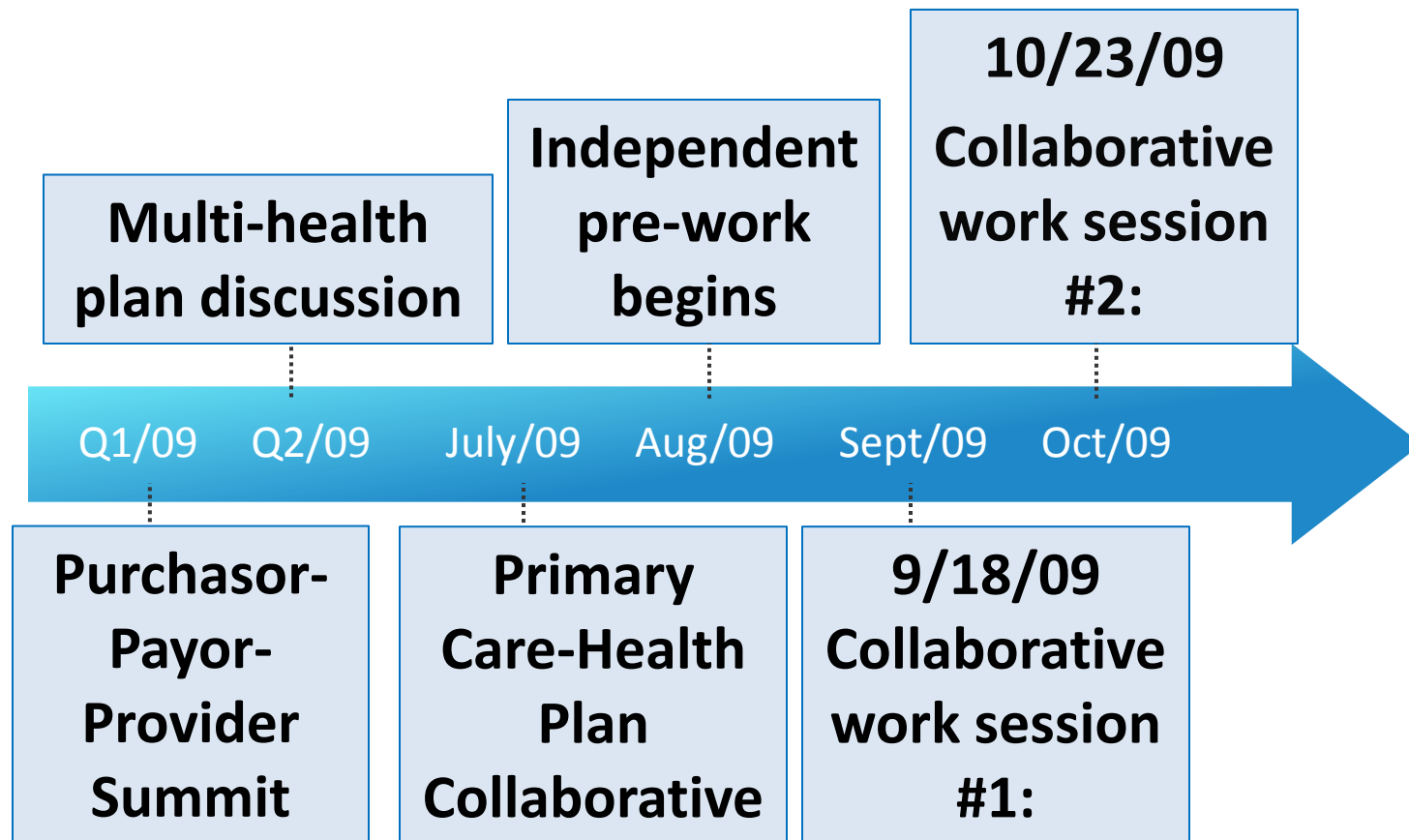
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## *What can be done to address these deficiencies?*



- **Transforming our current delivery system will require advancing patient-centered health care to optimize individual health**
- **A good place to start transformation at a local level is the advancement of patient-centered medical home (PCMH) innovation.**

# Central Ohio Patient-Centered Medical Home Project



# *Central Ohio Patient-Centered Medical Home Project*

## Project Purpose

To advance PCMH innovation in our community, starting with insured adults

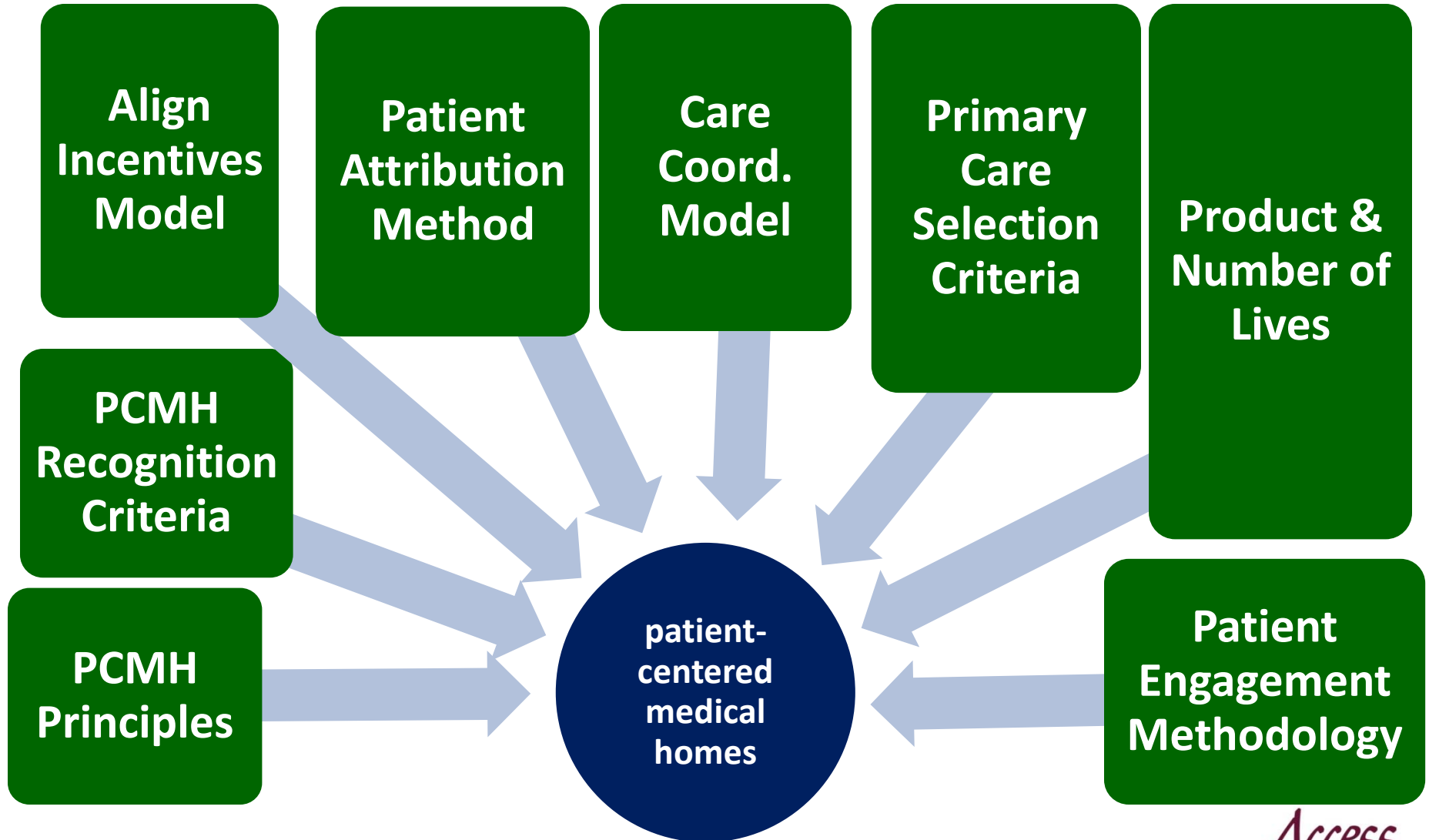
## Project Objectives

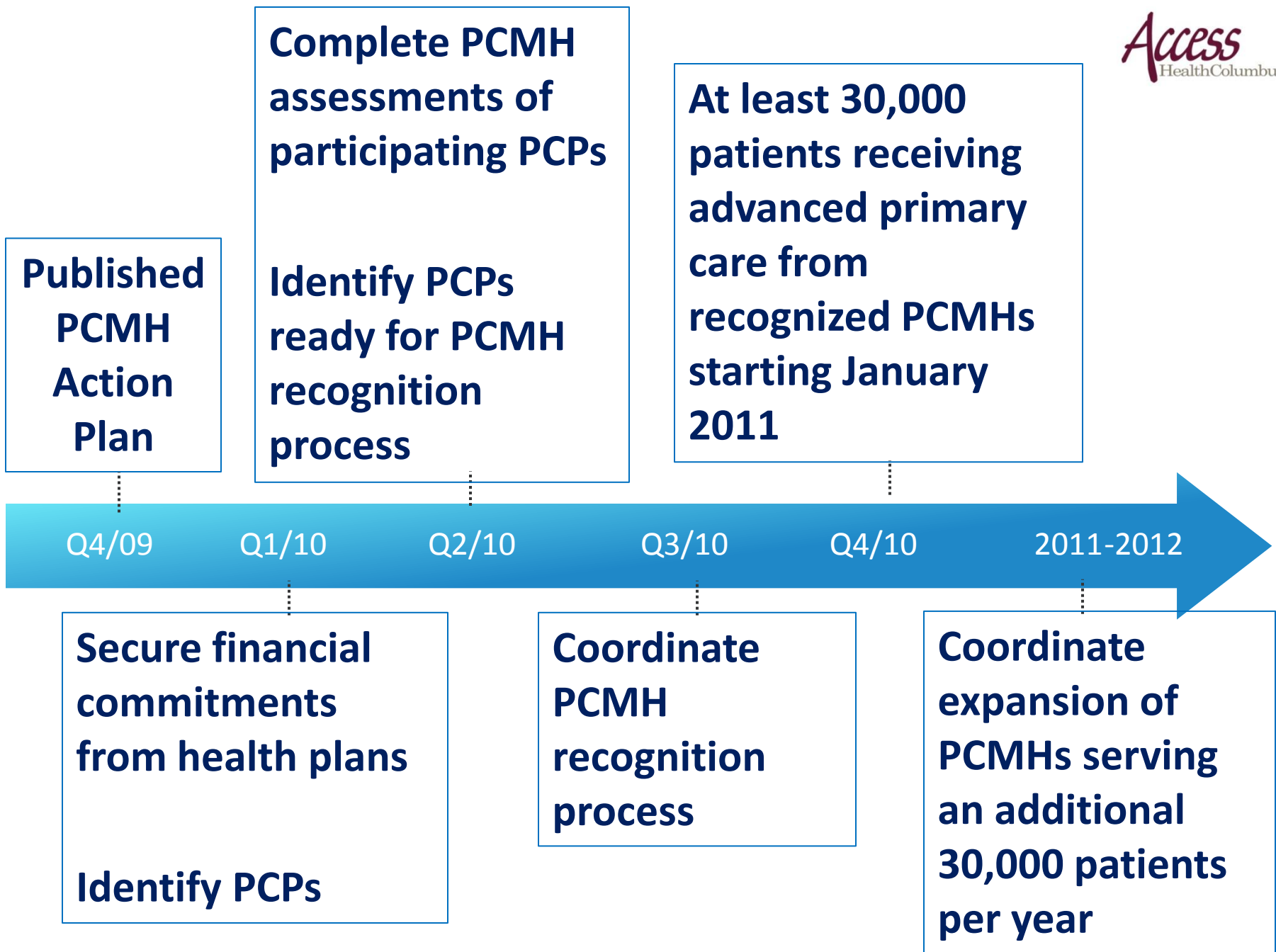
- **Strengthen Primary Care:** Improve care coordination and access
- **Payment Reform:** Align incentives between payors and providers

## Improvement Target

Starting in 2011 – up to 30,000 adults (each year for three years) with insurance coverage in central Ohio receiving care from Recognized PCMHs based on national standards

*Provider-Health Plan Collaborative  
PCMH Component Agreements  
November 2009*





# *Central Ohio Patient-Centered Medical Home Project*

## *Payment & reimbursement*



# *Central Ohio Patient-Centered Medical Home Project*

## Payment & Reimbursement approach:

- National Commission on Quality Assurance (NCQA) recognition is the chief currency of the medical home business model
- Participating health plans and self-insured employers will fund per-member-per-month (PMPM) for care coordination
- We will be assisting primary care organizations through a transformation process using NCQA standards
- Enhanced payments for care coordination & infrastructure will be based on NCQA recognition (estimated at \$48 - \$87 per patient/employee per year)

## *A summary on measuring financial ROI?*

| Patient-Centered Medical Reimbursement Model | Patient-Centered Medical Home Payments                            |
|----------------------------------------------|-------------------------------------------------------------------|
| Fee for Service:                             | Same as today                                                     |
| Care Coordination Fee:                       | \$48,000-\$87,000 per 1,000<br>(\$48 - \$87 per patient per year) |
| Pay for Improvement Incentives:              | Same as today                                                     |

| Measure          | 2007 (Ohio)                              | 12/31/2011: ROI Target                                                                                                             |
|------------------|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| ER Visit:        | 516 visits per 1,000<br>(476 in 1999)    | Reduce non-urgent ER visits by 10%<br>(~50 visit/yr * \$1,110/avg. payment<br>= \$55,500 savings per 1,000)                        |
| Hospital Admits: | 134 admits per<br>1,000<br>(117 in 1999) | Intervene to reduce preventable hospitalizations by 10%<br>(~13 admits/yr * \$8,292/avg. payment<br>= \$107,796 savings per 1,000) |

## A summary on measuring financial ROI?

Investment in Patient-Centered Medical Home Model has potential to improve VALUE of in year 1!

### Patient-Centered Medical Home Payments

Same as today

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(\$48 - \$87 per patient per year)

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Measure

2007 (Ohio)

12/31/2011: ROI Target

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# *Central Ohio Patient-Centered Medical Home Project*

## *Evaluation*



Excellent  
 Very good  
 Good  
 Average  
 Poor

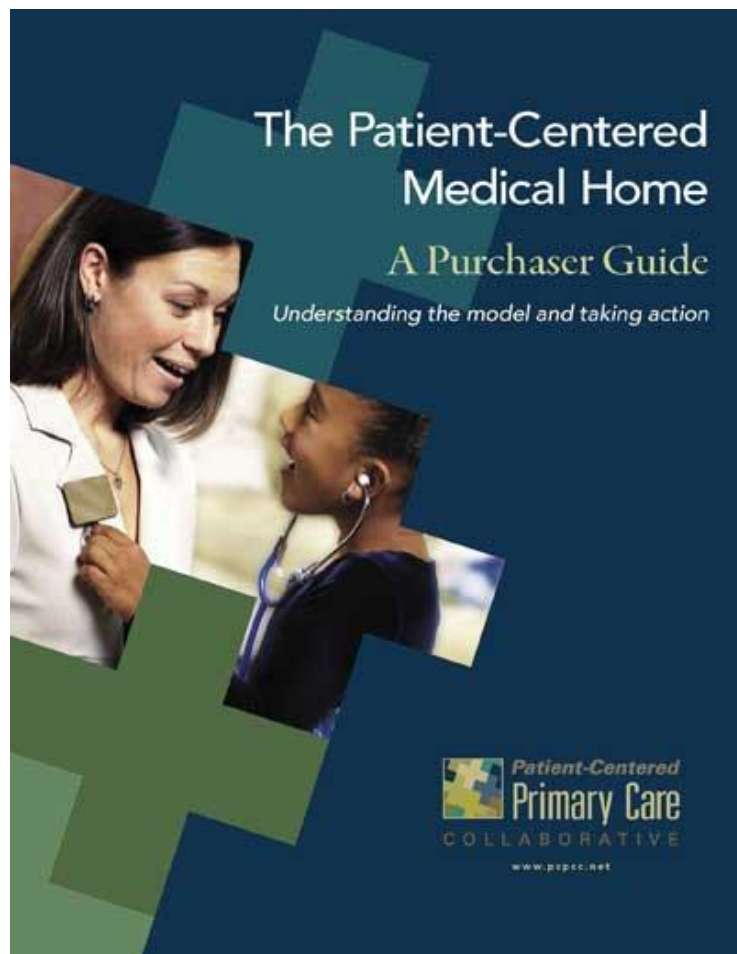
# *How will we evaluate improvements?*

## Evaluation of Patient-Centered Medical Homes focused on:

- **Improved access to care**
  - Be immediately accessible for patient concerns
  - Promptly treat acute illness
  - Create new opportunities to provide preventive care and chronic disease management
- **Controlling health care costs**
  - Prevent needless emergency department visits
  - Intervene early to reduce hospitalizations
- **Patient Engagement**
  - Effectiveness of care coordination
  - Effectiveness of patient-centered approach



# Central Ohio Patient-Centered Medical Home Project



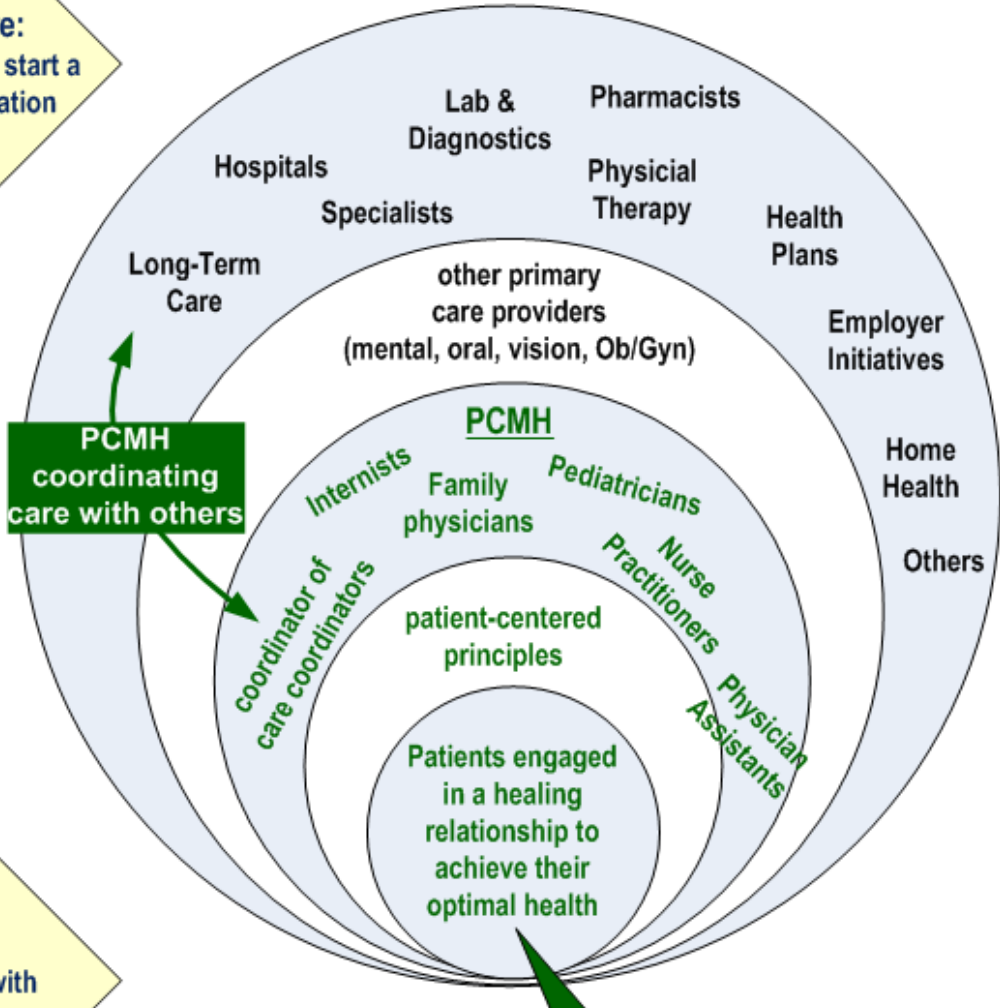
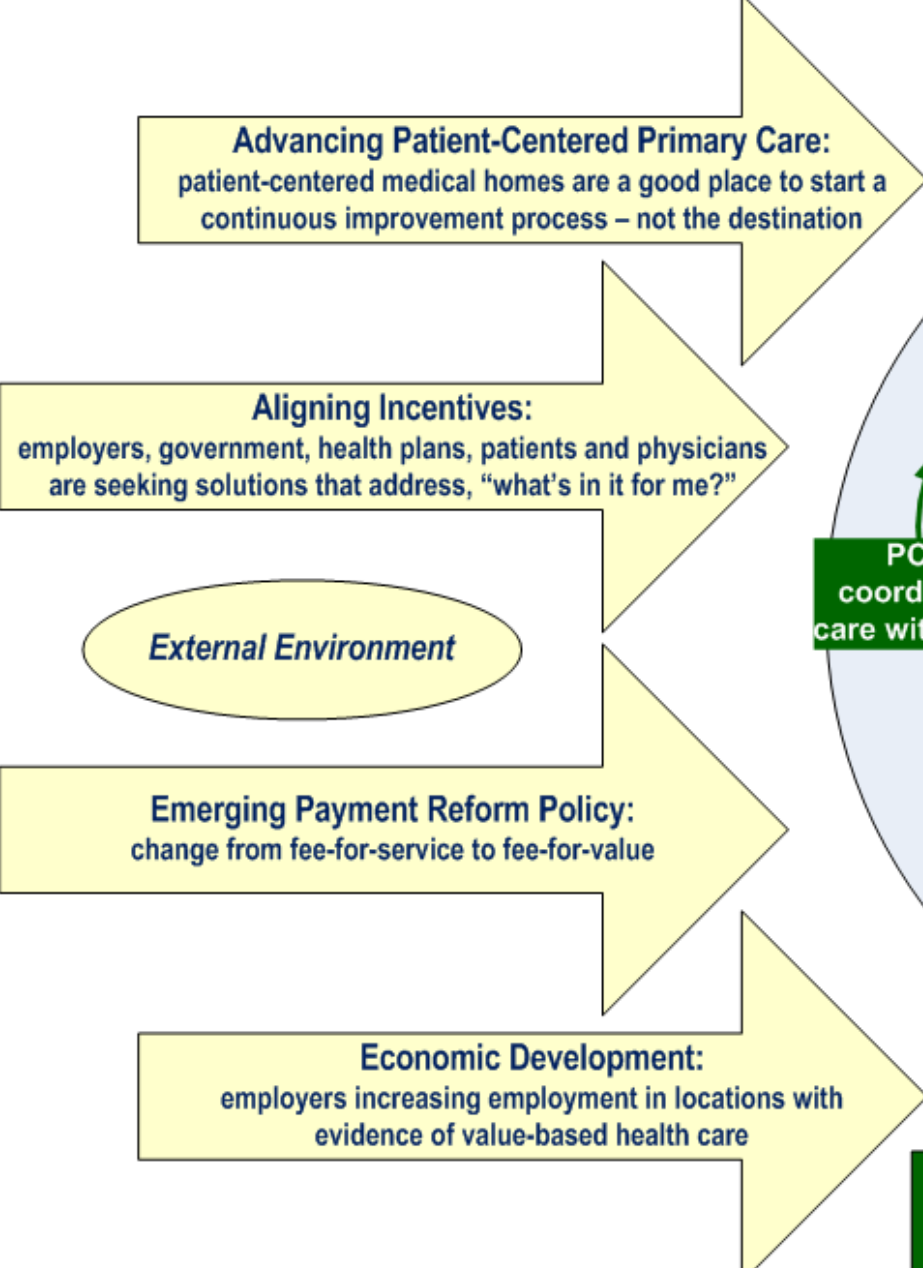
## *Engaging Purchasers*

# ***Central Ohio Patient-Centered Medical Home Project***

## **Strategies for Engaging Purchasers**

- **Commercial Health Plans**
  - **securing letters of intent from at least 3 health plans**
- **Self-Insured Employers**
  - **hosted two learning sessions**
  - **currently conducting 1-1 discussions to secure letters of intent**
- **Medicaid Health Plans**
  - **Working with Ohio Quality & Coverage Council**
- **Medicare**
  - **Preparing our primary care community for future opportunities**

# Transforming Our Health Care Environment: ... a shift to value-based health care grounded in patient-centered care



**Purpose of Patient-Centered Medical Homes (PCMH)**

# Central Ohio Patient-Centered Medical Home Project



## Engaging Primary Care Providers

# Patient-Centered Primary Care Learning Collaborative

Identify Physician & Administrative Champions

Voluntary Agreement to Participate in Primary Care Learning Collaborative

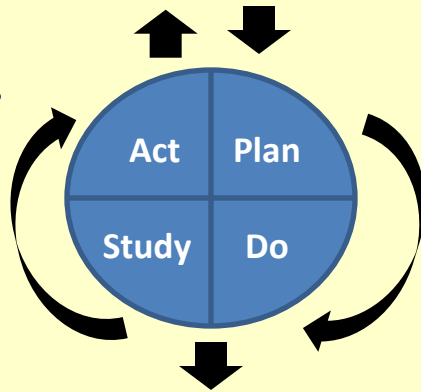
## Model for Improvement\*

What patient-centered improvements are needed?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Test Changes



after testing:  
IMPLEMENT changes on a broad scale

SPREAD changes to other parts of an organization or with other organizations

\* Source: Institute for Healthcare Improvements

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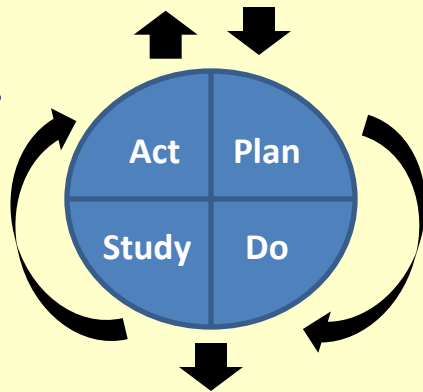
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# Patient-Centered Primary Care Project (PCMH) [assist 6-10 practices in 2010-11]

Facilitated Assessment using NCQA Medical Home Standards

Develop Improvement Plan for Each Primary Care Site

Provide Improvement Coaching Services

Utilize *Model or Improvement* to test and implement changes based on patient-centered medical home principles and standards

Complete NCQA Medical Home Application by 8/1/10

Contract with participating payors to fund care coordination effective 1/1/2011 as a recognized NCQA PCMH

Collaborate with patients, health plans, and employers to improve access to care and value

Measure & Report Quarterly Progress (cost effectiveness, access, satisfaction)

\* Source: Institute for Healthcare Improvements

# *Central Ohio Patient-Centered Medical Home Project*

## *Patient engagement & communication*



# *Exploring Patient Engagement Strategies (from a patient/consumer perspective)*

*What will my employer/purchaser need to do to get my attention & participation?*

*After I have selected my patient-centered medical home, what will I experience?*

*What is the best approach in developing my care plan to make it most meaningful for me?*

# *Questions?*

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