Home Sweet Medical Home

Building the Foundation For a New Healthcare System

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Health Care Expenses in an International Context

The U.S. spends significantly more per person on health care than other developed countries, both in total spending and out-of-pocket spending.

The Cost of Doing Nothing

Estimated Increase in CO Employer/Employer Share of Premiums in 2019

Without change, by 2025, 33-35% gross income for family of 4 will be consumed by health care costs

- $17,000
- $15,000
- $13,000
- $11,000
- $9,000
- $7,000
- $5,000

2009

- $5,563

2019

- $7,321
- $11,375 (104.5% Increase for Employees)
- $15,317 (109% Increase for Employers)

Employer Share of Premiums
Premiums per Worker
For All the Money We Spend, How Well Does Our System Perform?

A Commonwealth Fund study ranked the performance of the health systems of six countries, with 1 being the highest ranking and 6 being the lowest. The U.S. ranked at or near the bottom in 9 of the 10 categories.

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<td>Health Expenditures per Capita, 2004</td>
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Source: Country Rankings on Overall Health System Performance, Commonwealth Study, 2007 (2003 Data)
THE CURRENT SYSTEM IS UNSUSTAINABLE!!!
NOT ABOUT BAD DOCTORS and STAFF!

We need a NEW way of Thinking and NEW Systems to support the care we want to deliver

Trying harder will not work!!

Changing systems of care will...
As The Environment Swirls Around Us...
Push for Integration

• Market Consolidation
  • Hospitals buying physicians
  • Large physician groups forming
  • Integrated systems growing
Déjà vu... All Over Again?

• What’s different from Managed Care days?
  • Practice and community redesign
    • No-one taught us how before
    • Gatekeeper vs Gateway
    • Better tools (Technology) to coordinate care
    • Patient sophistication and engagement
  • Aligned incentives for ALL to work together
    • Quality
    • Affordability
    • Experience

• Realization that no one can do this alone!
It Takes A Region

Stakeholder Collaboration
- Shared Vision
- Leadership

Shared Data and Performance Measurement

Engaging Consumers
- Public disclosure
- Consumer Education
- Consumer-directed care decisions

Improving Healthcare Delivery
- IT Connectivity and Support
- QI Models and Activities
- Consensus Guidelines
- Care Management
- Provider Networks

Aligning Finance/Insurance
- Benefits promote cost/effectiveness
- Administrative Standardization
- Performance Incentives

Informed, Activated Consumers
Motivated, Prepared Practices
Supportive Insurance & Payment

Transformed Healthcare

Improved Health Outcomes & Reduced Costs

© MacColl Institute at Group Health
The Triple Aim
By The Institute for Healthcare Improvement

Population Health

Experience of Care

Per Capita Cost
A nonprofit collaborative working to redesign healthcare and promote integrated communities of care, using evidence based medicine and innovative systems

**GOALS**: to optimize health, improve quality and safety, reduce costs, and improve the care experience for patients and their healthcare teams.

We have trained over 450 practices, 2500 providers impacting well over 3 million patients!
How Are We Doing?

- Medical homes have yielded promising results ...
  - 29% reduction in ED visits at Group Health
  - 20% reduction in hospitalizations at Geisinger
  - Achieve 94% of diabetes patients having ≥2 primary care visits per year for NC Medicaid
  - Over $400 million saved over 4 years for NC Medicaid
  - 3.8% total cost savings in Iowa
  - 11% expected cost savings in VT
  - $640/year saved per patient for the community at Intermountain

... and are being widely adopted across the country

- 45 states are involved in medical home pilot activity

Patient-Centered Medical Home (PCMH)

An approach to providing high-quality, safe, continuous, coordinated, comprehensive care, with a partnership between patients and their personal health care team...

“The kind of care you’d want your Mom to have!”
The Colorado Multi-Payer PCMH Pilot
Pilot Parameters

- One of first in nation to launch - voluntary
- Three-year pilot
  - Ended April 2012
- NCQA PCMH Recognition
  - All but two practices received Level 3
- 16 Family & Internal Medicine Practice sites
  - 83 providers; 258 staff
- 7 Health Plans
  - Fee for service (FFS); Care management fee (PMPM); P4P
- 100,000 patients affected (20,000 covered)
Technical Assistance

• On-site Coaching

• Learning Collaboratives
  • Share lessons learned

• Using Data to Drive Improvement
What Have We Learned?
Making a House a Home!
IT’S MUCH MORE THAN JUST CHECKING A BOX

✓ NCQA
✓ AAAHC
✓ Joint Commission
✓ URAC
✓ Good Housekeeping Seal of Approval
What Do People Really Want?

• Trusting Relationship with Care Team
  • “I can reach someone who knows me, knows my history, can advise me and cares about my issues”

• Service
  • “I can get care or contact with someone when I feel I need to, without having to always come in”
  • “Less waiting in general” – during visits, for test results, for referrals, for refills, etc.

• Reliable, Coordinated Care
  • “My care is coordinated” – between providers, hospital/ER, home health, behavioral health, etc
What Do We Want?

• Trusting Relationship with Our Patients, Colleagues and Staff

• Job Satisfaction
  • Provide the best, most efficient care possible
  • Help patients reach their health highest health potential

• Work-Life Balance
Paradigm Shift

From Lone Physician ➔ Healthcare Team

From Ultimate Authority ➔ Shared Decision Making

From Acute Care ➔ Planned Proactive Preventive Care - Holistic Approach

From One Patient ➔ A Patient Population

From unwarranted variation ➔ Evidence-based medicine (protocols)

From guessing about our quality of care ➔ Knowing about our quality of care
Building a Solid Infrastructure
Fundamentals for Transforming

Practice Viability & Efficiency

Care Mgmt, Coordination & Communication

Leadership & Team Based Care

Patient Engagement & Access

Technology & Outcomes Reporting

Patient Centered Medical Homes
Tactics vs Culture

**Tactical**
- Technology
  - Registry/EMR
  - Health Information Exchange (HIE)
- Systems Redesign
  - Increased Access
  - Guidelines/Protocols
  - Workflow Redesign
  - Care Coordination/Care Management
  - Test/Referral Tracking

**Cultural**
- Leadership
- Team Based Care
- Patient Activation
  - Shared Decision Making
- Communication & Building Relationships
- Continuous Quality Improvement
“Culture eats strategy for lunch …over and over again.”

– Anonymous
Traditional Model
From Patient Point of View

“The doctor will be with you in just five more minutes.”
New payment models allow a new way of thinking!

- Transition from FFS “Treadmill Medicine” to coordinated planned management of entire panel, with extra care for those who need it
- Redefine “VISITS” – enhance access and convenience
  - 40 – 60% of primary care visits may not need to be in person
  - Secure email and/or phone
  - Save appointments for those needing it most (Outreach)
Using Data to Drive Improvement

• At the point of care
  • templates

• For those not coming in
  • outreach reports

• Quality reports – “OWN YOUR OWN”
  • to identify areas to focus on, monitor progress
  • demonstrate care to others
“And this button gives the computer a mild electric shock when I need to punish it.”
Patient Centered Planned Care

• **Before, During, and After Visit**

• **Develop Customized Care Plan**
  • Prevention, Chronic Conditions, Acute Care Issues
  • Shared-decision making – Patient Engagement!!

• **Warm Handover to Care Coordinator/Care Manager**
  • Track tests/referrals, coordinate with medical neighborhood, monitor registry (outreach and quality reports)
  • Engage patients, help them overcome barriers
  • Concentrate on high risk/high need patients
Care Coordination - Care Management

Internal

Care Coordination
- Lab and Referral Tracking
- Registry
- Navigator

Care Management
- Chronic Care Management
- Patient Self Activation
- Prioritizing High Risk / High Need
- Medication Adherence
- Prevention & Wellness

External

Medical Neighborhood
- Hospital System
- Specialists
- Mental/Behavior Health Systems
- Community Resources
- Shared Services
Patient-Centered Planned Care

Before the Visit

Prepared Care Team

Access

1. by visit
2. by e-mail
3. by phone

Front Office

Nurse/MA

Provider (MD/PA/NP)/Care Team

Before the Visit

CARE PLAN

Team-Based Care

Leadership

Self-Management Support

Technology

Care Coordination

Care Plan Management/Coordination

After the Visit

Follow-Up

Gather Patient Experiences

Population Management

Medical Neighborhood
(co-located or referred)

- specialists
- mental health
- dental/vision services
- hospitals
- pharmacy
- community resources
- social work
- home health
- complex case managers
- peer programs
- other ancillary services

Improved Outcomes

- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

HealthTeamWorks

Adapted from: www.NewHealthPartnerships.org

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Prioritizing Care Plan Management & Care Coordination

- Low Risk Patients
- High Risk Patients
- Single Chronic Condition and Complex Patients
- Multiple Chronic Conditions and Complex Patients

Prevention
“The most important feature [of transformation] is the patient-centered aspect. That’s very different than what I was trained to do. I was trained as a fund of medical knowledge. Patients would obediently follow my instructions. But it’s not about what we as providers want for our patients — it’s about what patients want for themselves. We must empower them to achieve those objectives. Patients are much more engaged in their care when it’s directed at their objectives.”

Jeffrey Kulp, MD, AgeWell Medical Associates in Colorado Springs
A Medical Home Without An Integrated Medical Neighborhood

Is Just An Island
Raise Your Hand if these issues are common in your practice?

10. You don’t know the people to whom you are referring patients.
9. Specialists say they don’t get needed information with a referral.
8. You don’t hear back from a specialist after a consultation.
7. Patients complain specialist didn’t know why s/he was there.
6. A referral doesn’t answer your question.
5. Your patient doesn’t come back to see you after a consultation.
4. A specialist duplicates tests you have already performed.
3. You are unaware that your patient was seen in the ER.
2. You are unaware that your patient was hospitalized.
1. You don’t have access to important data when you need it.
Integrated Community Care (Accountable Care Organizations)
Building The Medical Neighborhood

• Shared Resources – Expand “TEAM”
  • Complex Care Managers, Clinical Pharmacists, Social Workers, Educators, Mental Health Providers, Home Health…

• Specialists
  – Compacts

• Hospitals
  – Identification, Notification, Communication

• Mental/Behavioral Health
  – Overcoming HIPAA, Carve Outs

• Community Resources
  – Awareness and Connections
TRANSFORMATION IS HARD...

BUT DOABLE!
Change Fatigue?!
So Why Do It?
RESULTS!!!

The Triple Aim by IHI

- Population Health
- Experience of Care
- Per Capita Cost
Pilot Diabetes Data – thru March 2012
Pilot Prevention Data - thru March 2012

Number of Practices Reporting:
- Sept 2010: 6
- March 2011: 8
- March 2012: 13

Number of Patients:
- Sept 2010: 20,489
- March 2011: 27,756
- March 2012: 43,727
Patient Satisfaction

Feel they get care when they need it

Would recommend their practice to friends and family

Find their clinics well-organized, efficient and respectful of their time

Find it easy to speak to a physician
In 2010 – more generalized

In 2012 – directed at PCMH care model

- The nurses and doctors explain things in a way I understand.
- I am so pleased to have a team that knows me well and cares for me.
- It’s great having an after hours facility!
- When I first started coming here I was in no way in control of my health, now my confidence about taking care of myself has improved 100%
- I'm very impressed with how my PCP and my asthma doctor work together for my best medical care.
Colorado PCMH: Anthem Preliminary Year 2 Data

- 18% decrease in acute IP admissions/1000, compared to 18% increase in control group
- 15% decrease in total ER visits/1000, compared to 4% increase in control group
- Prescriptions/1000 increased as compared to control group
- Specialty visits/1000 remained around flat compared to 10% increase in control group

Overall Return on Investment estimates ranged between 2.5:1 and 4.5:1
From Pilots to “The Way We Do Business”
Comprehensive Primary Care (CPC) Initiative

- Colorado one of 7 regions selected nationwide by CMMI
- 4 year initiative involving
  - Medicare + several other payers
  - Over 500 practices selected nationwide
- Payment redesign
  - FFS + Care Management Fee + Shared Savings
  - Medicare – Avg $20 PBPM then $15 PBPM
- Practice redesign
IN SUMMARY
NOW IS THE TIME!!!

Carpe Diem
THIS WILL TAKE A COMPREHENSIVE TRANSFORMATION AT ALL LEVELS
CULTURE CHANGE FOR ALL!!

- Medical Groups
  - Willing to redesign and coordinate care
- Hospitals
  - Coordinate care - different business models
- Health Plans
  - Payment reform - data to practices/aggregators
- Employers
  - Participation in pilots - incent employees
- Patients/Consumers
  - Engage in their care and healthy outcomes - value based choices
Ultimately, working together to assist patients in achieving the highest level of health they can, preventing problems BEFORE they occur!
"Runners to your mark. Get set. Go! ... OK, come get your T-shirts."
Investment Required to Reduce CHAOS and Build Solid Infrastructure

IT’S ALL ABOUT RELATIONSHIPS!!

TIME

Today

Future
With Our PATIENTS!

With Our TEAM

With Our NEIGHBORS
SO...
CONGRATULATIONS!!

For stepping up to the plate and having the courage to build a better health care system for us and future generations!
QUESTIONS?

www.healthteamworks.org
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