Population Health for Rural Hospitals:
3. Patient Care Coordination and the Intensive Medical Home

National Rural Health Resource Center
Webinar Series: Population Health for Rural Hospitals
For February 25, 2015

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Value Based Care Group
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Agenda

1. Four defining trends in health care
2. The opportunity for quality & cost improvement
3. The PCMH opportunity
4. Three problems to overcome for PCMH development
5. A transitional solution: The Intensive Medical Home (IMH)
4 Defining Trends in Health Care

1. A revolution in medical science is shifting providers’ core function from acute care to disease management.

2. Dramatic slowing of growth in health care spending will force a restructured provider-patient relationship.

3. As FFS rates decline, physicians need new revenue models and sources based on their patients’ medical outcomes.

4. High-deductible and defined-contribution health plans are dramatically changing the health-care consumer experience.
The Opportunity for Quality and Cost Improvement

Care-defect costs as % of total cost by condition/procedure

- CHF
- COPD
- Diabetes
- Asthma
- Pneumonia
- Stroke
- CAD
- Hypertension
- AMI
- CABG
- Knee
- Hip
- Bariatric Surgery
- Overall

Source: Health Care Incentives Improvement Institute, Inc. Prometheus Payment 2009
The Current Medical Care Delivery Model

- Patients
  - Hospital
  - Specialists
  - Primary Care Phys.
  - Other Services
The Patient-Centered Medical Home Care Model

Patients

PCMH
- Family practitioner
- Nurse practitioner
- Health coach
- Care coordinator
- Dietary services
- Disease mgt.
- Behavioral health
- Rx management

Hospitals

Specialists

Home Care

Ancillary Services

Outpatient Services

Other Required Services
## The Potential for PCMH Cost Savings

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<tr>
<th>Column 1</th>
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¹ Centers for Medicare and Medicaid Services for 2011
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\(^1\) Centers for Medicare and Medicaid Services for 2011


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### PCMH-driven savings:

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**PCMH-driven savings:**

| 2nd year savings @ 5% (Conservative)                                 | $602,000      |

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<td>2(^{nd}) year savings @ 5% (Conservative)</td>
<td>$602,000</td>
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<tr>
<td>2(^{nd}) year savings @ 10% (Expected)</td>
<td>$1,204,000</td>
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Three Problems to Overcome with PCMH

1. Increased practice staffing costs
Increased PCMH Staffing Costs

Successful PCMH transitions by PCPs have required total staffing of 4.25 FTEs per physician—a 59% increase over current PCP staffing levels of 2.68 FTEs.

“Estimating the Staffing Infrastructure for a Patient-Centered Medical Home;”
Mitesh S. Patel, MD, MBA; Martin J. Arron, MD, MBA; Thomas A. Sinsky, MD; Eric H. Green, MD;
David W. Baker, MD; Judith L. Bowen, MD; and Susan Day, MD, MPH; Am J of Mgd Care
## Increased PCMH Staffing Costs

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<tr>
<th>Position</th>
<th>FTE</th>
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<tr>
<td>Provider FTE</td>
<td>1.00</td>
</tr>
<tr>
<td>Clerical</td>
<td>1.42</td>
</tr>
<tr>
<td>MA, technician, LPN</td>
<td>1.33</td>
</tr>
<tr>
<td>RN</td>
<td>1.33</td>
</tr>
<tr>
<td>RN care manager</td>
<td>0.40</td>
</tr>
<tr>
<td>NP/PA</td>
<td>0.25</td>
</tr>
<tr>
<td>Health coaches</td>
<td>0.25</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0.20</td>
</tr>
<tr>
<td>SW (includes mental health)</td>
<td>0.25</td>
</tr>
<tr>
<td>Mental health providers</td>
<td>0.25</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>0.10</td>
</tr>
<tr>
<td>Clinical data analyst</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.25</strong></td>
</tr>
<tr>
<td>Incremental FTEs for PCMH</td>
<td><strong>1.57</strong></td>
</tr>
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<td>Additional cost/mo.</td>
<td><strong>$10,062</strong></td>
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Three problems to overcome with PCMH

1. Increased practice staffing costs
2. Increased practice complexity
PCMH Care Model: Identify and Manage Care for Patient Populations (NCQA must pass elements 2-4 & 6)

- Evaluate entire patient population
- Establish criteria to risk-stratify patient population (3B)
- Perform risk stratification
- Identify high risk patients
- Develop and implement targeted care management interventions/care plans for high risk and top priority condition patients (3C must pass)
- Promote/support patient self-management (4A must pass)
- Generate appropriate reminders for preventive and chronic care services (2D must pass)
- Measure and continuously improve performance (6A & 6C must pass)
- Review clinical data from Practice Management System/EHR/Patient Medical Records/County-state Population Health Data
  - Problem lists—acute & chronic conditions (2B)
  - Medication lists (2B)
  - Comprehensive Health Assessments (2C)
  - Dates previous physician visits (2A)
- Identify high priority clinical conditions (3A*)
- ID Top 3 priority conditions for practice population (3A)
- Implement evidence-based clinical guidelines for priority conditions (3A)
- ID subsets of pts with top priority conditions

*NCQA PCMH Recognition Standards/Factors noted in parentheses
Three Problems to Overcome with PCMH

1. Increased practice staffing costs
2. Increased practice complexity
3. Need for higher practice revenue to make it all worthwhile
   a. Short term
   b. Longer term
A Transitional Solution: The Intensive Medical Home

- PCP practice(s) hire RN Care Manager, paid for by contracting payer(s)
- Payer identifies current PCP patients in the top 10% of members who drive 65% of costs
Healthcare’s Pareto Rule

Concentration of Health Care Spending in the U.S. Population, 2010

Percent of Total Health Care Spending

Percent of Population, Ranked by Health Care Spending

NOTE: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Healthcare’s Pareto Rule

Concentration of Health Care Spending in the U.S. Population, 2010

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<tr>
<th>Percent of Population, Ranked by Health Care Spending</th>
<th>Percent of Total Health Care Spending</th>
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<tbody>
<tr>
<td>Top 1% (≤$53,238)</td>
<td>21.0%</td>
</tr>
<tr>
<td>Top 5% (≤$18,086)</td>
<td>49.5%</td>
</tr>
<tr>
<td>Top 10% (≤$10,044)</td>
<td>65.2%</td>
</tr>
<tr>
<td>Top 15% (≤$6,696)</td>
<td>75.0%</td>
</tr>
<tr>
<td>Top 20% (≤$4,639)</td>
<td>81.7%</td>
</tr>
<tr>
<td>Top 50% (≤$829)</td>
<td>97.3%</td>
</tr>
<tr>
<td>Bottom 50% (≤$829)</td>
<td>2.7%</td>
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A Transitional Solution: The Intensive Medical Home

• PCP practice(s) hire RN Care Manager, paid for by contracting payer(s)
• Payer identifies current PCP patients in the top 10% of members who drive 65% of costs
• 1 RN Care Manager per 200 patients
  • Conducts detailed patient assessment with established PCP
  • Offers medical and psychosocial support
  • Coordinates care with patient’s established PCP, outside providers
    • Behavioral Health psychologist
    • Dietician
    • Health coach
    • Social worker
    • Pharmacist
• Typical patient characteristics
  • Multiple chronic diseases
  • Poor lifestyle choices (weight, smoking, no activity)
  • Incompletely treated depression, anxiety, substance abuse
Coordinated Care Management

• Case Management
  • Care transitions, gaps in care
• Chronic disease /Predictive modeling
• Behavioral health integration
• Pharmacy-medication reconciliation
• Patient activation
The BCBS-Illinois IMH experience

- Established 2012
- Covers 10% of commercially insured members accounting for 65% of total cost
- Engages 300 PCPs and “enrolls” 5,000 high-risk patients
- Pays PCP groups $48 pmpm to hire nurse care managers
- PMPM goes to $65 when engagement rate reaches 90%
- 1 RN Care Manager per 200 patients
- BCBS IDs high-risk patients in chronic disease categories most amenable to intervention
- BCBS provides support and regular reporting to PCPs
- PCP also receives $277 for 1-hour (no-copay) care-plan-development visit
- 72% patient-engagement rate with Care Manager outreach
  - Versus 10% engagement rate with payer outreach only
- 7.8% annual savings after 2 years
- Successful programs can graduate to full ACO shared-savings status
Geisinger’s experience

- Geisinger embedded case managers with PCP practices for 33,000 patients to facilitate improved quality and coordination of care

- Results:
  - Better care: 18.2 percent decrease in acute admissions; 20 percent decrease in readmissions
  - Lower costs: 7.1 percent reduction in the total cost of care over five years
  - Estimated savings: $16,600,000
Value-Based Payment Implementation (BCBS-IL)

Provider Financial Risk/Reward

3rd Pty FFS
Traditional Payments

PCP/PCMH Care-Mgt Fees
Quality-Based Revenue Enhancement

Risk/Reward-Based Payments

Shared Savings
Shared Risk/Reward
Capitation/% Premium

Non-Savings Incentive Payments

Traditional Payments

Value-Based Payment Implementation (Geisinger)

Provider Financial Risk/Reward

Time

3rd Pty FFS
Traditional Payments

PCP/PCMH Care-Mgt Fees

Quality-Based Revenue Enhancement

Shared Savings

Shared Risk/Reward

Capitation/ % Premium

Risk/Reward-Based Payments

Non-Savings Incentive Payments
In Summary: IMH Program Advantages

- Offers high-impact transitional care-coordination model as PCP practice evolves to full PCMH
- Requires very little or no provider IT investment
- Payer provides data and support
- Payer covers cost of RN Care Coordinator
- Payer identifies high-risk patients with existing PCP relationship
- Provides care-coordination, team-management learning curve for PCP
- Allows evolution to full PCMH practice
- IMH provides transitional model in evolution to full value-based reimbursement
- Allows payer to engage cooperatively with key providers
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