Patient-Centered Medical Home
Review of the Evidence for Impact on Cost

Karen Fitzpatrick, MD, PCMH CCE
Associate Professor (clinical)
West Virginia University Family Medicine
Patient Centered Medical Home Fellowship Director
Medical Director, Quality and Ambulatory Informatics
fitzpatrickk@wvuhealthcare.com
Strong Primary Care: infrastructure for high-value healthcare

- First contact care
- Early intervention
- Identify & Modify Risk
- Whole person focus
- Longitudinal care
- Trusted relationship

Experienced with:
- Interactions of Health and Behavior
- Drivers of poor health
- Interventions at teachable moments
- Addressing barriers to health improvement
- Balancing competing treatment priorities
- Family /Community context
Primary Care provided 69% of chronic condition outpatient visits. The majority of hypertension, asthma, depression, COPD and diabetes visits were managed by Primary Care.
Patient Centered Medical Home (PCMH) is “New and Improved” Primary Care

A “best practice” model for the delivery of high-value primary care and

A primary care practice redesigned with key evidence-based enhancements that deliver better healthcare value

Also known as:
“medical homes”
“health homes”
“advanced primary care”
“medical care coordination”
“patient-aligned care teams”

“Joint Principles of the Patient Centered Medical Home” 2007
The model endorsed by all primary care professional organizations AAFP, ACP, AAP, AOA
Patient-Centered Medical Home
Evidence-based Enhancements for Primary Care

Patient-Centered
Supports patients in managing decisions and care plans.

Comprehensive
Whole-person care provided by TEAM

Coordinated
Care is organized across the ‘medical neighborhood’

Committed to quality and safety
Maximizes use of health IT, decision support and other tools

Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours.
Enhanced Primary Care impact on the continuum of health

- **Highly Complex Conditions (5%)**
  - Case management
  - Care coordination & planned care
  - Rapid response for advice / exacerbations
  - Patient/ family/ caregiver support
  - End-of-life planning
  - Whole person approach

- **Complex Conditions (30%)**
  - Self-care support
  - Evidence based Risk Reduction
  - Planned follow up care
  - Appropriate specialist referral & testing
  - Rapid access for advice/care

- **Simple Conditions At Risk (70%)**
  - Preventive Screenings
  - Immunizations
  - Rapid access for advice/ illness
  - Risk Factors Reduction
  - Early intervention

- **Healthy (70%)**
Evaluations of PCMH Impact: 2013-14
Patient Centered Primary Care Collaborative Annual Review, 2015

Aggregated outcomes from the 28 peer-reviewed studies, state government program evaluations, and industry reports:

- 17 found improvements in cost
- 24 found improvements in utilization
- 11 found improvements in quality
- 10 found improvements in access
- 8 found improvements in satisfaction

CHALLENGES
- Broad array of enhancements
- Difficult to measure degree of implementation
- Limited payment reform
- Lack of aggregated data
- Results take TIME
**Intervention:**

750,000 Medicaid non-dual eligible
“Medical Homes” with enhanced access, quality improvement and care coordination
$2.50 PMPM CM fee plus FFS
Regional networks/ Community-based case management supported with $3 PMPM

**Results**

Significant Cost Savings (p<0.005)
- 2008 $52 PMPM
- 2009 $80 PMPM
- 2010 $72 PMPM
- 2011 $120 PMPM

Reduced rate of hospitalization (despite higher risk) while rate *increased* for non-enrolled (p<0.001)
Intervention:
- 1 million members in PCMH program
- Practice facilitators
- Shared data
- Bonus tied to quality and cost
- Fee boost for NCQA PCMH

Results
*Lower utilization for PCMH vs. other members::*
- 16% ED adult care
- 14% ED Medicare Advantage
- 13% ED Pediatrics
- 2% Medicare Readmission rate
- 12% adult inpatient surgery
- 25% Medicare medical inpatient care
**Intervention:**
PCMH providers chose one of three tiers
- Case management fees and quality bonuses
- Central population health / disease management
  - 2010 added community networks
  - 2013 practice-based health coaching

**Results**
- Annual growth of PMPM 1.5% vs national rate of 3%
- Total ROI 562%
- 12% in ED Visits
- Significant reduction in hospitalizations for COPD, CHF, and pneumonia
- Improved preventive screenings, appropriate treatment
- High patient (70%) and provider satisfaction (91%)
Interventions:
NCQA standards guided redesign
Improved Access
Team-based care
Multidisciplinary team for Care Transitions
Nurse Case Managers for High-Risk Care Coordination
Entire staff participated in Culture of Improvement

Results--Cost/ Utilization
Highmark 2012-2013 –lower overall cost by $66 PMPM for 1082 patients
Geisinger Health Plan 2012-2014
-43% Medical –Surgical Admissions
-52% Readmissions
-14% ED utilization

Quality
Diabetes A1c testing and control from 25th percentile to 75th percentile
Improved 7 and 14 day post-hospital follow-up by 20%
Improved Highmark PCMH quality from Level 2 to Level 3 (41 of 50 possible points)
PCMH Approach:

right care, right place, right time

Barry Smith
35 year old restaurant worker
Diabetes
Foot neuropathy
Previous toe amputation
Poor glucose control A1c 12%

2011-2012
Recurrent foot infections
three ED Visits with hospitalization
A second amputation
Fall 2012
PCMH *Practice-based* Nurse Case Management
- Frequent insulin adjustment with PCP
- Monitored wound status till amputation
- Coordinated PCP and specialist visits
- Increased self-care ability

2013
Hypertensive urgency treated successfully as outpatient

2013
Foot blister treated successfully as outpatient

No ED visits or hospitalizations for next 18 months
Maintained glucose control, full time work and active lifestyle!
Case Series:
A1C Levels decrease with Case Management

![Graph showing A1C levels decrease with case management over time.](image-url)
Wide acceptance

40,000 providers
Over 8000 practices

37 States with PCMH initiatives (public or private)

NOT the only standard
NCQA PCMH in West Virginia

Total of 44 recognized practices
28 Level 3
40 FQHCs
3 academic-affiliated practices
2 private group
208 providers
About 12% of WV Primary Care
Discussion ?