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Measuring the Performance of the Medical Home

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Agenda

- Key Distinctions: Primary Care Practice vs. Medical Home
- Economic Impact: Costs
- Potential Savings
- Breakeven Scenario
- Conclusions

Primary Care Practice vs. Medical Home

	Primary Care Practice	Medical Home
Primary Provider	Primary Care Physician	PCP with health coaches
Provider Accountability	Limited incentives for quality	Increased incentives through transparency
Physician's Role	Trusted source	Trusted source supplemented by others; member of a collaborative health care delivery team
Care	Fragmented	Integrated, whole person oriented, anywhere/anytime
Care coordination	Disintermediated to disease management industry	Responsible and reimbursed
Primary Incentive	Visits & procedures (volume)	Patient adherence to self-care regimen
Decision Support	Limited, largely physician-patient relationship	Customized, internet and personal coaching, EMR & EBM guided

Economic Impact: Costs

	Incremental Cost	Assumption
EMR with Registry Functionality and Knowledge Management Tools for Clinicians	$80-120K initial investment, $5-20K ongoing maintenance per medical home	EBM and Clinical Decision Support Guided Practice – 300,000,000 US Population / 1-2,000 patients per medical home * incremental costs
Physician Revenue for care coordination	$100-115 K per PCP	$50-100 per patient in panel
Health Coach	$78K + 56% load	Load for benefits, coaching tools, etc
Data Manager	$65K / 3 FTE	1/3 FTE per medical home
Panel size		1-2K, depending on prevalence and intensity of chronic care management requirements
Physician Incentive	$150-400K	$500/patient in panel, inclusive of clinical performance bonus, current state $350-600K vs. future state $.5-1MM

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Potential Savings

	Metric
Acute	10% fewer hospital admissions; 20% fewer ER visits; 10% less absenteeism
Diagnostic	20% fewer tests
Therapeutic	Prescriptions should increase with more patient adherence, but overall medical costs should decrease ~30%[1]

1. www.dartmouthatlas.org/atlases/2006_Chronic_Care_Atlas.pdf

Breakeven Scenario

- Medical cost drivers:
  - Health coaching and increased effectiveness in patient enrollment in disease management programs.
  - Health coach can manage 250 disease management patients on average
  - 150K new medical homes (300 million US population / 2K panel size) with total system cost = 150K x cost drivers
  - Future medical cost trend 8%, non medical cost trend 4%
- 4 years to breakeven

Conclusions

Implications of Medical Home for Key Stakeholders

Primary Care Physicians	• Practice revenue would increase by $100,000 for care coordination accountabilities, with $20,000 at risk in incentives for clinical performance. • Physicians would face more responsibility and a learning curve to manage care coordination. • Clinical resource expenses would increase as health coaches are added to the practice to help the physician coordinate care. • The physician's office would have an EMR to track clinical data to identify care coordination opportunities. The EMR would also support follow-up for patients' e-mails, medication adherence and other direct outcomes of care. • Medical homes would add to the prestige of primary care physicians and help to stem the brain drain in the field.
Large Multi-specialty Groups	• Large multi-specialty groups could lose power and prestige as PCPs control more of the clinical activity via the medical home. • With the enhanced care coordination medical homes provide, more patients could control their chronic conditions, resulting in fewer referrals to specialists. • Hospitals could face up to a 30 percent decrease in revenue. In response, they will need to consider ways to diversify traditional revenue streams. • Should hospitals decide to become medical homes themselves, primary care physicians could become employees of the hospital if they don't want to assume total responsibility for managing their medical home patient panels. Hospitals, in turn, would need to develop reward systems to align physician incentives for care coordination services. • Hospitals could also provide the registries, decision support, expert systems and knowledge management capabilities needed to support the medical home and its new role in the community.
Health Plans	• Crisp work flows would be needed to integrate with the medical home care coordinators to minimize any duplicated services or gaps in care. If the medical home is responsible for care coordination, health plans may need to redirect their care coordination services elsewhere since they wouldn't be compensated – unless employers bought-up additional clinical services beyond those provided by the medical home. • If the health plan has insourced care management that is sold as a standalone product, there could be risk to the medical management revenue stream, as the medical home would be in direct competition for care coordination with health plans. • Health plans would need to offer more real-time, bi-directional data flows between their systems and medical homes to leverage the homes' clinical tracking and decision support systems. The health plan could maintain its role as data aggregator but offer better IT interfaces to the medical homes' EMRs so that physicians have a more up-to-date clinical record with outcomes. • Utilization could decrease as a health plan's network medical homes deliver better care coordination, resulting in improved profitability and decreased loss ratios. One note of caution: Health plans could find themselves under fire for excessive profits, which might prompt additional competitors to enter their market.
Employers	• As health care purchasers, employers will benefit from a more rational care delivery system that incentivizes providers for clinical outcomes. • Medical homes could help to stabilize rising health care costs, thus making it easier for employers to continue providing employee health benefits. • Lower health care costs would enable U.S. companies to compete more effectively in an international marketplace. • Employers could see that their investments in employee health are efficient, effective and improve the bottom line.
Life Sciences and Technology Companies	• The resulting medical cost savings from the focus on care coordination could free-up funding from acute care to invest in start-up ventures to supply the medical home. • The need for new technologies to support medical homes' information and expert systems could lead to a new era in product innovation. • As the use of EMRs becomes widespread, a push for health information exchanges (HIEs) as a conduit to share the resulting data could ensue. HIEs would be better supported as society appreciates health information technology investments and their direct results on improved health. • As savvy computer users age, they will want to "medically wire" their homes to synch them up to their medical home and help them better adhere to their physicians' recommendations.
State Government	• Public health programs could develop initiatives to better support physicians and their medical home responsibilities. • Indigent care should improve as medical homes better coordinate care to keep patients out of expensive inpatient settings. • Crime could decrease as behavioral health patients are better tracked via care coordination.
Federal Government	• The medical home could help the U.S. economy achieve a fixed ratio of medical cost growth to GDP growth and help to sustain the country's health care financing model. • Supporting a medical home model could result in more rational physician workforce planning with a redirection of residency training support to more primary care specialties.

Conclusions

- Better health care delivery model
  - Wagner's Chronic Care Model provides a more comprehensive approach to primary care
  - More holistic and integrated care
  - More physician-patient collaboration
  - Teachable moments to reinforce information and knowledge sharing
- Reimbursement reform to pay physicians for care coordination will promote evidence-based medicine and higher quality care
  - Realigned incentives would correct inappropriate care variation
- Opportunities for providers to partner with each other for economies of scale on technology
- Improved clinical and financial outcomes would yield a more productive and competitive workforce in an increasingly global economy

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