Towards a High Performance Health System: Potential of Patient-Centered Primary Care “Medical Homes”

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Washington, D.C.
May 23, 2008

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Aiming for a High Performance Health System

- What is the vision? A High Performance Health System
  - Opportunities to Improve Access, Outcomes and Cost Performance
- Key Strategies for Change
  - Coverage: Access, Quality and Efficiency
  - Bending the Curve: Savings and Value
- Potential and Role of Patient-Centered Medical Homes
  - Payment and support systems
  - U.S and International approaches
- Moving forward
Why Not the Best?: Commonwealth Fund Commission National Scorecard on U.S. Health System Performance

- **Long, Healthy & Productive Lives**: 69
- **Quality**: 71
- **Access**: 67
- **Efficiency**: 51
- **Equity**: 71

**OVERALL SCORE**: 66

- 37+ Indicators
- U.S. compared to benchmarks

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006
Aiming Higher: Commonwealth Fund Commission State Scorecard on Health System Performance

State Scorecard Summary of Health System Performance Across Dimensions

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Access</th>
<th>Quality</th>
<th>Avoidable Hospital Use &amp; Costs</th>
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Source: Commonwealth Fund State Scorecard on Health System Performance, 2007
International Comparison of Spending on Health, 1980–2005

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Mortality Amenable to Health Care
U.S. Rank Fell from 15 to Last out of 19 Countries

Deaths per 100,000 population*

* Countries’ age-standardized death rates, ages 0–74; includes ischemic heart disease.
Five Key Strategies for High Performance

1. Extend affordable health insurance to all

2. Align financial incentives to enhance value and achieve savings

3. Organize the health care system around the patient to ensure that care is accessible and coordinated

4. Meet and raise benchmarks for high-quality, efficient care; Information systems

5. Ensure accountable national leadership and public/private collaboration

Extending Affordable Insurance for All Essential for High Performance

- Access barriers to essential care; Inequities
- Poor access to care is linked to poor quality and inefficient care
- Fragmented health insurance system makes it difficult to control costs
  - Financing of care for uninsured and underinsured families is inefficient
- Design matters: Positive incentives in benefit design and insurance markets are lacking

**Percent of adults who had any of three access problems* in past year because of costs**

<table>
<thead>
<tr>
<th>Country</th>
<th>Below average income</th>
<th>Above average income</th>
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<tbody>
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<td>6</td>
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<td>24</td>
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<tr>
<td>US</td>
<td>37</td>
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</table>

* Did not see a doctor, skipped test, treatment, or follow-up, or did not fill Rx or skipped doses because of cost.

AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom; US=United States.

Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

Percent of adults ages 19–64 with at least one chronic condition*

- **Insured all year**
- **Insured now, time uninsured in past year**
- **Uninsured now**

- Skipped doses or did not fill prescription for chronic condition because of cost
  - 18%
  - 58%
  - 59%

- Visited ER, hospital, or both for chronic condition
  - 16%
  - 27%
  - 35%

*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Adults Without Insurance Have More Problems With Lab Tests and Records

Percent of adults ages 19–64 reporting the following coordination problems in past two years:

- Test results or records not available at time of appointment
- Duplicate tests ordered
- Never received lab/diagnostic test results or delay in receiving abnormal results
- Any lab test/record problems

New Coverage for 44 Million Uninsured in 2008

- Employer Group Coverage TOTAL = 142 m
- National Insurance Connector TOTAL = 60 m
- Medicaid/ SCHIP TOTAL = 42 m
- Medicare TOTAL = 43 m

Improved or More Affordable Coverage for 49 Million Insured

Aiming for a High Performance, High Value Delivery System

• Attributes
  – Timely patient access to appropriate care
  – Clinical information available to all providers at time of care and to patients
  – Patient care is coordinated among providers and during transitions across sites
  – Care systems are accountable for outcomes and to each other
  – Payment systems aligned with outcomes and support innovation, learning

• Core strategies to achieve integrated, accountable care systems
  – Payment incentives and organizational change
  – Central role and potential of primary care and medical home approaches
  – Infrastructure to meet and raise performance benchmarks
Bending the Curve: Options to Achieve Savings and Improve Value

- Producing and using better information
- Promoting health and disease prevention
- Aligning incentives with quality and efficiency
- Correcting price signals in the health care market

Fifteen Options that Achieve Savings Cumulative 10-Year Savings

Producing and Using Better Information
- Promoting Health Information Technology: -$88 billion
- Center for Medical Effectiveness and Health Care Decision-Making: -$368 billion
- Patient Shared Decision-Making: -$9 billion

Promoting Health and Disease Prevention
- Public Health: Reducing Tobacco Use: -$191 billion
- Public Health: Reducing Obesity: -$283 billion
- Positive Incentives for Health: -$19 billion

Aligning Incentives with Quality and Efficiency
- Hospital Pay-for-Performance: -$34 billion
- Episode-of-Care Payment: -$229 billion
- Strengthening Primary Care and Care Coordination: -$194 billion
- Limit Federal Tax Exemptions for Premium Contributions: -$131 billion

Correcting Price Signals in the Health Care Market
- Reset Benchmark Rates for Medicare Advantage Plans: -$50 billion
- Competitive Bidding: -$104 billion
- Negotiated Prescription Drug Prices: -$43 billion
- All-Payer Provider Payment Methods and Rates: -$122 billion
- Limit Payment Updates in High-Cost Areas: -$158 billion

Cumulative Impact on National Health Expenditures of Insurance Connector Approach Plus Selected Individual Options

Dollars in Billions

Savings to NHE


$0 400 800 1,200 1,600 2,000

$31 $84 $163 $272 $407 $573 $770 $997 $1,258 $1,554

Annual Net Impact  Cumulative Impact

Savings options include: Health Information Technology, Center for Medical Effectiveness, Public Health, Episode-of-Care, Strengthening Primary Care, Benchmark Rates, and Prescription Drug Prices.

Total National Health Expenditures, 2008 – 2017
Projected and Various Scenarios

Dollars in Trillions

- Projected under current system
- Insurance Connector plus selected individual options*
- Spending at current proportion (16.2%) of GDP

*Savings options include: Health Information Technology, Center for Medical Effectiveness, Public Health, Episode-of-Care, Strengthening Primary Care, Benchmark Rates, and Prescription Drug Prices.

Savings Can Offset Federal Costs of Insurance For All: Federal Spending Under Two Scenarios

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollars in billions</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>$82</td>
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<tr>
<td>2012</td>
<td>$122</td>
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<tr>
<td>2017</td>
<td>$205</td>
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* Federal spending under insurance alone
* Net federal with insurance plus savings options

* Selected options include improved information, payment reform, and public health.
Data: Lewin Group estimates of combination options compared with projected federal spending under current policy.
Strengthening Primary Care and Care Coordination in Medicare: Distribution of 10-Year Impact on Spending

Dollars in billions

SAVINGS
-$250
-$200
-$150
-$100
-$50
$0
$50
$100
$150
$200
$250

COSTS
-$250
-$200
-$150
-$100
-$50
$0
$50
$100
$150
$200

Systemwide
Federal Gov't
State and Local Gov't
Private Payer
Households

-$193.5
-$156.9
-$4.1
-$9.1
-$23.4

What is a Medical Home?

“A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

– American Academy of Pediatrics
Key 2007 International Survey Findings

- In each country, having a “medical home” improves patient experiences:
  - Patient safety
  - Coordination: with specialists/across sites of care; duplication & delays
  - Patient satisfaction
  - Chronic care management

- But many in each country do not have such medical homes

Coordination Problems: Medical Records Not Available During Visit or Duplicative Tests

Percent with coordination problems

<table>
<thead>
<tr>
<th>Country</th>
<th>Has medical home</th>
<th>No medical home</th>
</tr>
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<tbody>
<tr>
<td>AUS</td>
<td>11</td>
<td>27</td>
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<tr>
<td>CAN</td>
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<td>US</td>
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</table>

Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.

Safety: Any Patient-Reported Error

Base: Adults with chronic condition
Percent any medical, medication, or lab error

Note: Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors. Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.

Patient-Centered, Coordinated Primary Care

Medical Homes as Part of A Systems Approach to Access, Quality and Efficiency

• Superb, timely access to care
• Patient engagement in care
• Information systems that support high-quality care
• Routine patient and clinical information feedback to doctors
• Coordinated care, integrated and team care
• Incentives and system support to improve/innovate

Approach to patient-centered care, redesigned primary care
  – Part of “system” of care that aims to organize care around the patient and focus on outcomes
Waiting Time to See Doctor When Sick or Need Medical Attention, 2007

Primary Care Doctors: Practice Has Arrangement for Patients’ After-Hours Care to See Nurse/Doctor, 2006

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., “On The Front Lines of Care: Primary Care Doctors’ Office Systems, Experiences, and Views in Seven Countries,” Health Affairs Nov. 2, 2006).
Lawton Chiles Children and Family Health Care Center (Brandenton, Florida)

- Implemented open access in 2002
- Connected each patient with personal MD or NP
- Increased hours of operation to include weekends
- Instituted patient care teams:
  - Divided staff into 6 cells or teams
  - Trained teams to perform all functions
  - Cross trained clinical team and staff
  - Expanded role of existing staff (e.g., referral clerk becomes receptionist)

- Outcomes:
  - Wait time to schedule well child visit decreased from 14 to < 1 day.
  - Office wait times dropped from 66 to 45 minutes, and then from 45 to 9 minutes when a patient care coordinator was added to the team
  - Hospitalizations for children dropped dramatically (from approximately 1800 to 775 per year)

International Innovations in Access “After-Hours” - Early Morning, Nights and Weekends

• Denmark
  – County-wide physician cooperatives with phone and visit center
  – Computer connections to medical records
  – Reduce physician workload; increase phone consults

• Netherlands
  – 2000/2003: Cooperatives evening to 8 AM and weekends;
  – Nurse led with physician available, backup;
  – Office visits and house calls
  – Reduce physician workload and use of emergency rooms, ambulance calls; now integrating with electronic records

• UK
  – Walk in centers
  – National Help Line: NHS Direct

• Multiple points of access: email, electronic medical records

Information Systems and Infrastructure
Where Are We on IT?
Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity

Percent reporting EMR

Percent reporting 7 or more out of 14 functions*

*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., “On the Front Lines of Care,” Health Affairs Nov. 2, 2006.)
Denmark Leads the Way In IT and Patient-Centered Primary Care: An Example of High Performance

- Highest public satisfaction with health system among European countries
- Strong primary care base with after-hours service
- Health information technology and information exchange
  - 98% of primary care physicians totally electronic health records and e-prescribing
  - Paid for e-mail with patients
  - All prescriptions, lab and imaging tests, specialist consult reports, hospital discharge letters flow through a single electronic portal accessible to patients, physicians, and home health nurses
  - Specialist payment depends upon filing information in the electronic portal
MedComm – The Danish Health Data Network

GP’s with EDI: 2150 = 98%
Specialists with EDI: 639 = 80%
Hospitals with EDI: 63 = 100%
Pharmacies with EDI: 331 = 100%
Doctors on Call: 15 = 100%
Health Insurance: 17 = 100%
79 messages /min

Prescriptions
1289023 = 87%
Disch. Letters
1054314 = 88%
Lab. reports
844528 = 98%
Referrals
115597 = 60%
Reimbursement
21049 = 92%
Lab Requests
44385 = 15%

Why Invest in E-Health?
Denmark Physicians and Patients Example

• Doctors:
  – 50 minutes saved per day in GP practice
  – Information ready when needed
  – Telephone calls to hospitals reduced by 66%
  – E-referrals, lab orders
  – Patient e-mail consultation, Rx renewal

• Patients:
  – Reduced waiting times, greater convenience
  – Info about treatments, number of cases
  – Patients access to own data
  – Preventive care reminders
  – Info about outcomes

Engaging Patients and Managing Care
Chronic Care Model and Medical Home Fit Together

- Chronic care model requires a team, patient-centered approach, IT support
- Country initiatives around disease management or frail elderly have elements related to building medical homes
Primary Care Practice Capacity to Generate Patient Information

Percent of primary care practices reporting easy to generate

- List of patients by diagnosis
- List of patients' medications, including Rx by other doctors

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., “On the Front Lines of Care,” Health Affairs Nov. 2, 2006.)
Country Initiatives

Incentives for Quality Improvement
- UK: GP Contract
- New Zealand: Primary Health Organizations
- Australia: Practice Incentives Program; reimbursement for coordination, and nurse support
- Germany: Global fees, Statutory Disease Management Programs
- Sweden: Co-location of services; expanded use of nurses
- Netherlands: Support for nurses on primary care team

Information Technology and Electronic Medical Records
- UK: Connecting for Health
- Canada: Health Infoway
- Germany and Australia: Electronic, portable personal health records
- Denmark: National HIT and exchange
Community Care of North Carolina

Asthma Initiative: Pediatric Asthma Hospitalization Rates
(April 2000 – December 2002)

In patient admission rate per 1000 member months

- 15 networks, 3500 MDs, >750,000 patients
- Receive $3 PM/PM from the State
- Hire care managers/medical management staff
- PCP also get $3 PMPM to serve as medical home and to participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2004) - $10.2 Million; Savings (Mercer analysis) $124M compared to FY2003; Savings $225M compared to Medicaid FFS

Source: L. A. Dobson, Presentation to ERISA Industry Committee, Washington, DC, Mar. 12, 2007 (Updated 2/29/08)
Disease Management German-style

- Conditions: Diabetes, COPD, coronary heart disease, breast cancer
- Funding from government to 200+ private insurers (sickness funds)
  - Insurers receive extra risk-adjusted payments to cover patients with these conditions
  - Insurers pay primary care docs to enroll eligible patients into programs & provide periodic reports back to the docs (the closest to coordination)
  - Patients: reduced cost sharing if enrolled
  - Care guideline protocols plus patient education
  - Country-wide evaluation of results
Medical Home System Examples Exist in U.S.: More than One Model of Medical Home

Community Care of North Carolina

ALASKA NATIVE MEDICAL CENTER

THE POLYCLINIC

GEISINGER REDEFINING BOUNDARIES

Level One Care for ALL

Group Health
Strategies to Spread and Support Development of Enhanced Primary Care
Primary Care and Accountable Coordinated Care Systems

- Encourage development and selection of a medical home
  - Recognition of primary care practices with medical home capacity
  - New capitation payment to primary care practices in return for access, coordination
  - Revise relative value scales
- Incentives for physicians to band together into real or virtual networks
  - Separate capitation payment to support community nurse/coordination networks. North Carolina example
  - Bundled payments and episodes of care. Example global rate for hip replacement, up to 90 days post-operations
- Incentives for patients to designate medical home
- Expand and develop use of electronic health records, information exchange, and decision support
- Quality, outcomes and patient experience feedback systems
National Measures to Recognize Medical Homes Exist: Physician Practice Connections (PCMH)

Practice must demonstrate proficiency in at least five areas to qualify as PCMH, such as:

- Written standards for patient access and patient communication; use of data to show meet this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three conditions
- Active support of patient self-management
- Tracking system to test and identify abnormal results
- Tracking referrals with paper-based or electronic system
- Measurement and reporting of clinical and/or service performance by physician or across the practice

Bridges to Excellence Medical Home Payment Initiative

- A multi-state, multiple employer initiative which gives primary care physicians $125/patient covered by participating employer for providing “medical homes”
- Participants include large employers (Ford, GE, Humana, P&G, UPS, and Verizon), health plans, NCQA, MEDSTAT and WebMD, among others
- Medical home metrics include: follow-up on referrals to other MDs, systematically tracking tests, flagging abnormal results in a standardized way, and adhering to medical guidelines to monitor and treat chronic conditions like diabetes and hypertension
- Improvements in quality is estimated to save $250-$300 per patient in the first year

Opportunities for Provider and Public Action: Participate, Innovate, and Advocate

• Support affordable and universal health insurance, including simplification
• Align financial incentives to enhance value; organize around episodes of care
• Redesign care around the patient
  – Follow patient journey through practice & hospital
  – Obtain patient experience feedback
• Meet and raise benchmarks for high-value care
• Ensure accountable leadership and collaborate
Moving Forward: Why Not the Best?

- **Insurance**
  - Expand to all with focus on care and continuity
  - Population focus on outcomes
- **Payment**
  - Realign incentives, positive support to change
  - Levels and methods to encourage more integrated, organized care
- **Capacity to practice as a “system” and medical home**
  - HIT and Exchange: Develop adequate information systems
  - Enhance coordination and connections across sites of care
  - Rapid access, after-hours care; Multiple points of access
  - Co-location and teams; community support services
- **Aiming High: Achieving consensus requires that everyone participate and come together for the greater good**
Thank You! Acknowledgments

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