

Central Ohio Patient-Centered Medical Home Project

Benefit-Cost Summary

February 2010

What is a Patient-Centered Medical Home and why is it different?

A Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care. The PCMH is a health care setting that facilitates the partnerships between individual patients and their personal physicians – and when appropriate – the patient’s family. At the core of a PCMH is a physician-directed medical practice committed to organizing and coordinating care based on patients’ needs and priorities, communicating directly with patients and their families, and integrating care across settings and practitioners.

TODAY’S CARE		MEDICAL HOME CARE
My patients are those who make appointments to see me	→	Our patients are those who are registered in our medical home
Patients’ chief complaints or reasons for visit determines care	→	We systematically assess all our patients’ health needs to plan care
Care is determined by today’s problem and time available today	→	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	→	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	→	A prepared team of professionals coordinates all patients’ care
I know I deliver high quality care because I’m well trained	→	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	→	Acute care is delivered by open access and non-visit contacts
It’s up to the patient to tell us what happened to them	→	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor’s needs	→	A multidisciplinary team works at the top of our licenses to serve patients

The goal of advancing PCMHs is to improve the quality of care, reduce the need for expensive medical services and generate savings for purchasers and consumers. In order to achieve this goal, the alignment of incentives is required between primary care practices, health plans, employers, and the engagement of consumers. The PCMH is complementary (not intended to replace) employee health initiatives, such as wellness programs.

What changes for the stakeholders?

Employers <ul style="list-style-type: none"> • Realign payments/contracts • Create incentives for employees to use PCMH 	Patient <ul style="list-style-type: none"> • Learn to manage chronic diseases • Enter into patient-physician agreement
Health Plans <ul style="list-style-type: none"> • Improved matching of patients to provider • Additional monthly payments to primary care teams for coordination of care 	Provider <ul style="list-style-type: none"> • Better access & communication with patients • Improved care coordination

What do the stakeholders gain?

Employers <ul style="list-style-type: none"> • Better value for health care expenditures • Increased employee productivity 	Patient <ul style="list-style-type: none"> • Better access to appropriate care • More satisfied as a patient/consumer
Health Plans <ul style="list-style-type: none"> • Better utilization of scarce resources • Potential for lower acute care costs 	Provider <ul style="list-style-type: none"> • Provide better chronic & preventative care • Be rewarded for work that is valued by all

Project Coordinated By:



Lead Support:



Major Support:



Additional Support:



What is the potential return on investment?

Program investments range from \$4.00-\$7.25 per patient/employee per month (\$48 - \$87 per patient/employee per year) based on a PCMH's level of transformation, as measured by the National Committee for Quality Assurance (NCQA).

Anticipated Return on Investment:

At 12 months:	Break-even
Years 2 & 3:	Approx. 15% for Medicare and commercial patients ¹

According to *Proof in Practice²: A compilation of patient-centered medical home pilot and demonstration projects*, an investment to redesign the delivery of care around PCMH yields an excellent return on investment (after the initial 12 months).

	Reductions in ER visits	Reductions in Hospitalizations
Community Care (North Carolina)	16%	40% for asthma
Genesee Health Plan (Michigan)	50%	15%
Group Health Cooperative of Puget Sound (Washington)	29%	11%
HealthPartners Medical Group (Minnesota)	39%	24%
John Hopkins (Maryland)	15%	24%

What is the shared risk?

- Will health plans and employers sustain their commitment to the transformational change?
- Will patients engage in managing/improving their own health care?
- Will providers make and sustain the transformational change?

How will progress be measured?

We intend to utilize existing evaluation tools to measure progress, such as HEDIS. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

Why should I participate in the Central Ohio Patient-Centered Medical Home Project?

Health Plans/Employers	Patients	Providers
<p>Patients in a medical home incur 15–20 percent less (risk-adjusted) total health care spending per year than patients treated by regional peers, without evidence of reduced quality (<i>American Medical Home Runs, Health Affairs. 2009</i>).</p>	<p>Patients with medical homes are more likely to report better access to care, coordination of care, communication with their primary care provider, and fewer medical errors. Medical homes do not just improve, but actually eliminate, disparities in getting needed medical care (<i>Why the U.S. Needs Medical Homes, The Commonwealth Fund 2009</i>).</p>	<p>Increased health plan reimbursement (if recognized as a PCMH based on national standards); improvements in patient experience; reduction in clinician/staff burnout, and improved quality of care (<i>Patient-Centered Medical Home Evaluation, The American Journal of Managed Care. 2009</i>).</p>

When do employers and health plans need to make decisions?

By Q2 2010, letters of intent from health plans and employers are needed indicating their financial commitment to reimburse recognized Patient -Centered Medical Home beginning in Q1 2011.

¹ Estimated percentage by which payer's risk adjusted total per capita health spending is below regional average, excluding shared savings payments made to the primary care sites, (*American Medical Home Runs, Health Affairs. 2009*).

² Published October 2009 by the Patient-Centered Primary Care Collaborative (www.pccpc.net)