What it Really Takes to Have a Successful Patient Centered Medical Home

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Background

Tufts Health Plan has a long history of provider collaboration

- Tufts Health Plan (THP) has had provider risk sharing arrangement for 15+ years and has always believed in collaborative models. These groups have become the PCMH.
- In 2007, THP entered into arrangements with groups with limited group risk (P4C, P4P, Surplus sharing) as part of a growth initiative
- In 2008, anticipating cuts in CMS revenues, THP Leadership wanted an assessment of the performance of these models, which addressed the following :
    - Evaluate program value from administrative and medical cost standpoints
    - Address whether the MA product was viable in the long term given anticipated funding cuts from CMS
    - Address whether the model needs to change to succeed in the impending environment, to one of more control by THP and more retention of surpluses?
- The study showed :
    - Physician groups in gain sharing models had better financial and clinical outcomes
    - There was a significant difference across the performance of groups in gain sharing deals
- THP decided to keep the model and define ways to improve the performance of groups willing to accept the help

Setting the Stage: Evolution of Care Management

THP's geriatric-focused model links existing medical management functions and capabilities with transition management across the care continuum

1 Inpatient Length of Stay

- Manage length of inpatient continued stay and place of services
- Emphasis on episodic care with minimal to no planning

2 Complex Ambulatory Management

- Manage costs by coordinating services across the continuum to avoid redundancies / duplication
- Emphasis on safety and assisting member with complex illness or injury in movement to less costly level of care

3 Population Disease Management

- Manage costs by improving member self-care and self management capabilities to avoid admissions
- Emphasis often on one disease even for members with multiple chronic conditions
- Often siloed from other initiatives available to support members

4 Moving to Integrated Transition Management

- Redesign and integration of existing components enabling a geriatric, "holistic" approach
- More emphasis on managing member care transitions
- Greater focus on avoidable admissions and readmissions
- IP case managers focus more time on cross functional discharge planning versus concurrent review
- Enhanced ambulatory care management, supporting face-to-face visits for select members
- Executed by RNs with geriatric backgrounds and / or training

Although additive, none of the first three efforts fully address the cost drivers and issues for seniors who need integrated support as they transition through the care delivery settings

Focus on Transition Management

Transition Management can significantly improve quality of life and reduce unnecessary utilization

4

Moving to Integrated Transition Management

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- Transitions with a high potential for sub-optimal outcomes include:
  - Moving from one care provision environment to another
    - Home → Hospital
    - Hospital → Extended Care
    - Extended Care → Home with services
  - Change in the constellation of healthcare providers or caregivers
    - Family disruption
    - Loss of community resources
  - Onset of a new health problem
- Transitions frequently result in
  - Preventable deterioration in member’s health status
  - Use of otherwise avoidable services and costs
- No single point of accountability exists to ensure complication-free transitions

PCMH and NCQA Standards

There are only two requirements of 2011 PCMH NCQA Standards that are not required as part of the TMP PCMH

Standard	Content Summary
PCMH 1: Enhance Access/Continuity	• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours
	• The practice provides electronic access
	• Patients may select a clinician
	• The focus is on team-based care with trained staff
PCMH 2: Identify/Manage Patient Populations	• The practice collects demographic and clinical data for population management
	• The practice assesses and documents patient risk factors
	• The practice identifies patients for proactive reminders
PCMH 3: Plan/Manage Care	• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems
	• Care management emphasizes:
	– Pre-visit planning
	– Assessing patient progress toward treatment goals
	– Addressing patient barriers to treatment goals
	• The practice reconciles patient medications at visits and post-hospitalization
	• The practice uses e-prescribing
PCMH 4: Provide Self-Care Support/ Community Resources	• The practice assesses patient/family self-management abilities
	• The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources
	• Practice clinicians counsel patients on healthy behaviors
	• The practice assesses and provides or arranges for mental health/substance abuse treatment
PCMH 5: Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
	• The practice manages care transitions
PCMH 6: Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve
	• The practice tracks utilization measures such as rates of hospitalizations and ER visits
	• The practice identifies vulnerable patient populations
	• The practice demonstrates improved performance

The only NCQA requirements that are not also required by TMP

Outcomes of the Model

PCMH Findings

The risk contracts do provide a medical cost advantage to THP over Fee for Service models

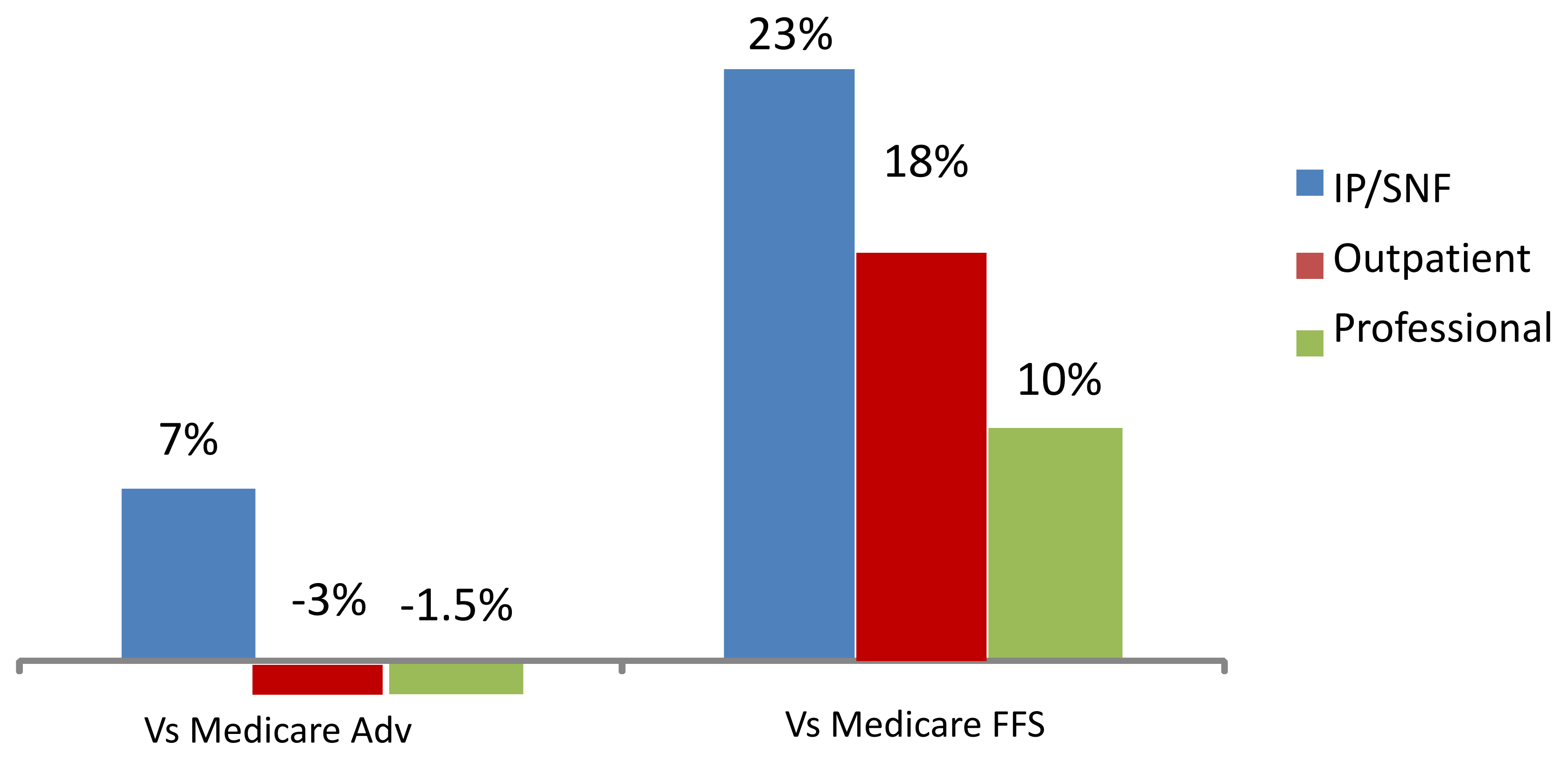
Comparison of total $PMPM Performance vs. Benchmarks for Medicare Advantage and Medicare FFS

	vs Medicare Adv	vs Medicare FFS
PCMH	3%	19%
No PCMH	(4%)	10%

The 19% performance gap represented over $100M in medical costs for the population managed

Components of Medical Cost for PCMH

We found that the Provider based risk contracts managed inpatient (and readmissions) more effectively and was the main source of savings even as OP & Professional costs rose



PCMH Findings – High Cost Cases

The PCMH arrangement also managed their highest cost cases much more effectively than the benchmark

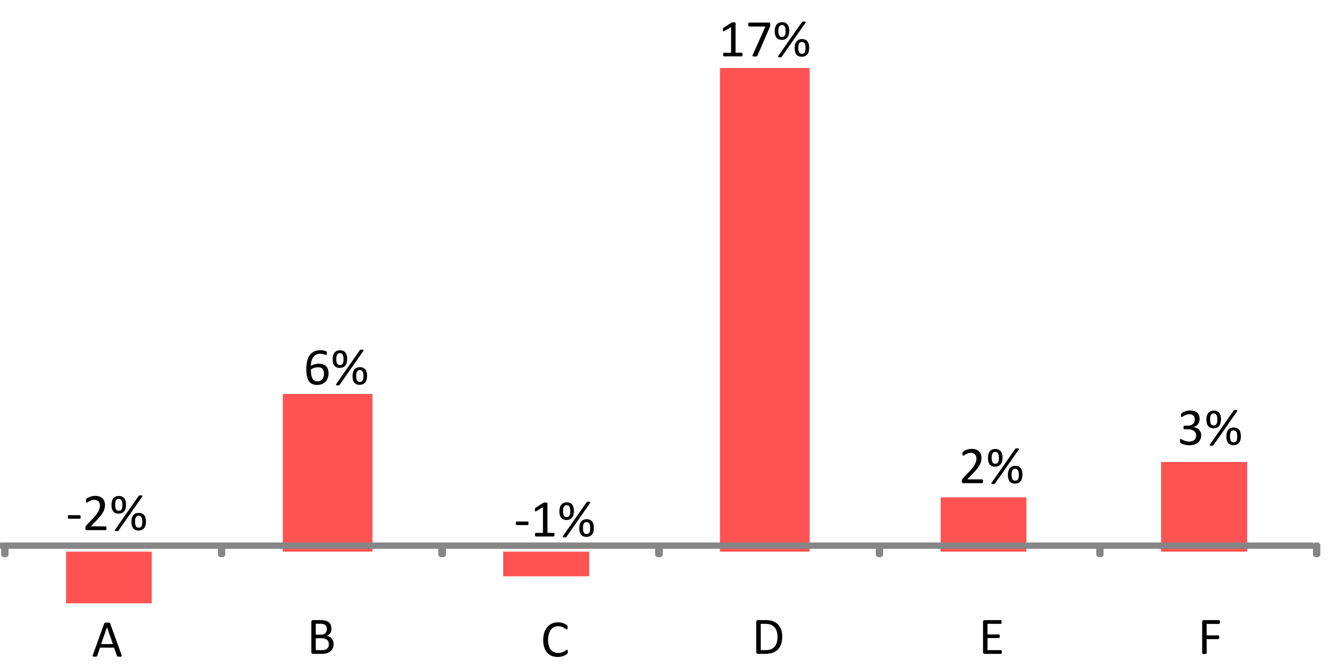
Comparison of $PMPM Performance for the top 1% of Members vs. Benchmarks for Medicare Advantage and Medicare FFS

	PCMH	No PCMH
vs Medicare Adv	9%	-20%
vs Medicare FFS	40%	4%

The 40% performance gap represented over $4,400 PMPM in medical costs for the population managed

Medical Cost Performance by PCMH Group

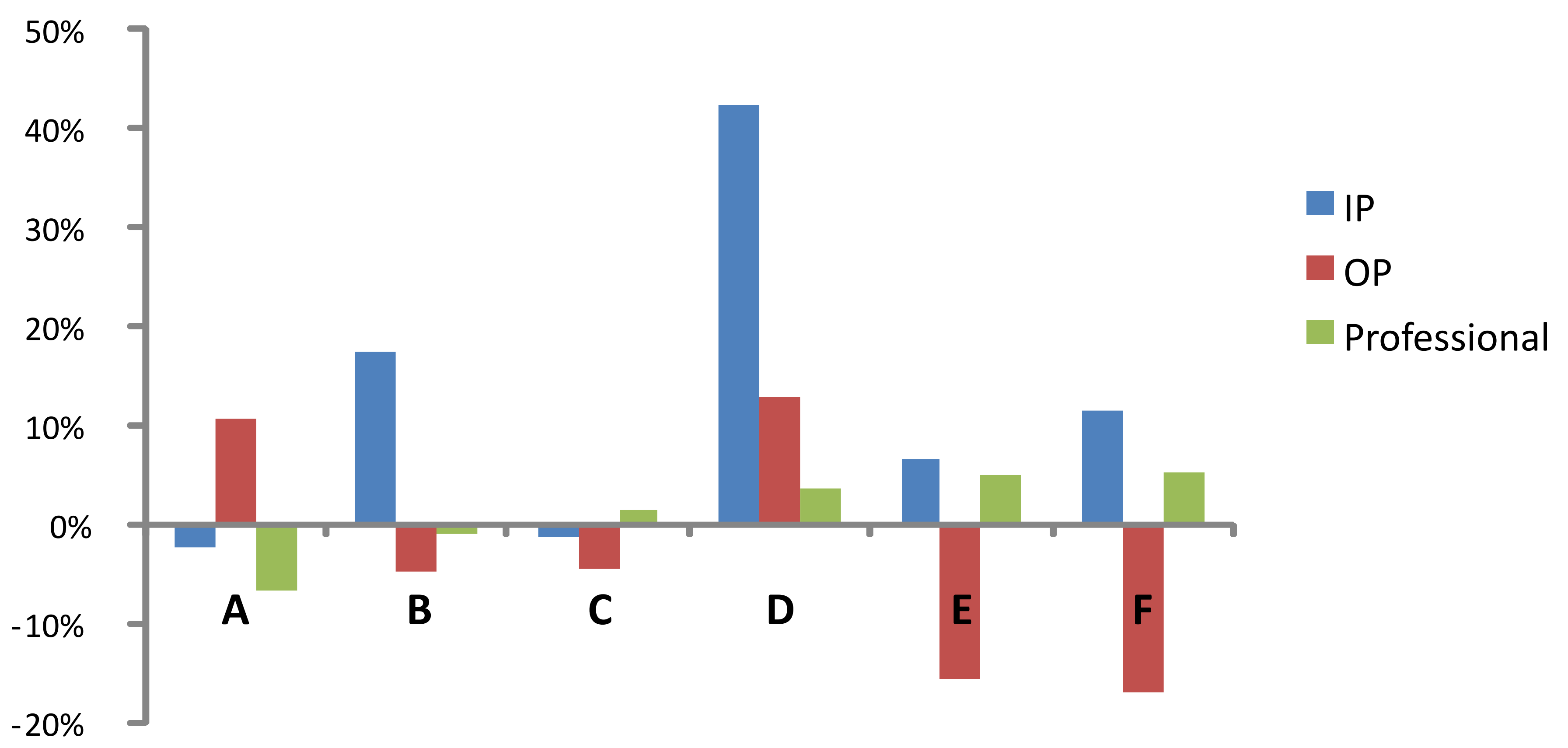
Within the gain sharing arrangements, there were significant differences in physician group performance



The Best performing group had medical costs $150 pmpm better than the worst performing group

Components of Medical Cost by PCMH Group

The groups that performed well did so by managing inpatient costs and some outpatient costs



Key Components of the Model

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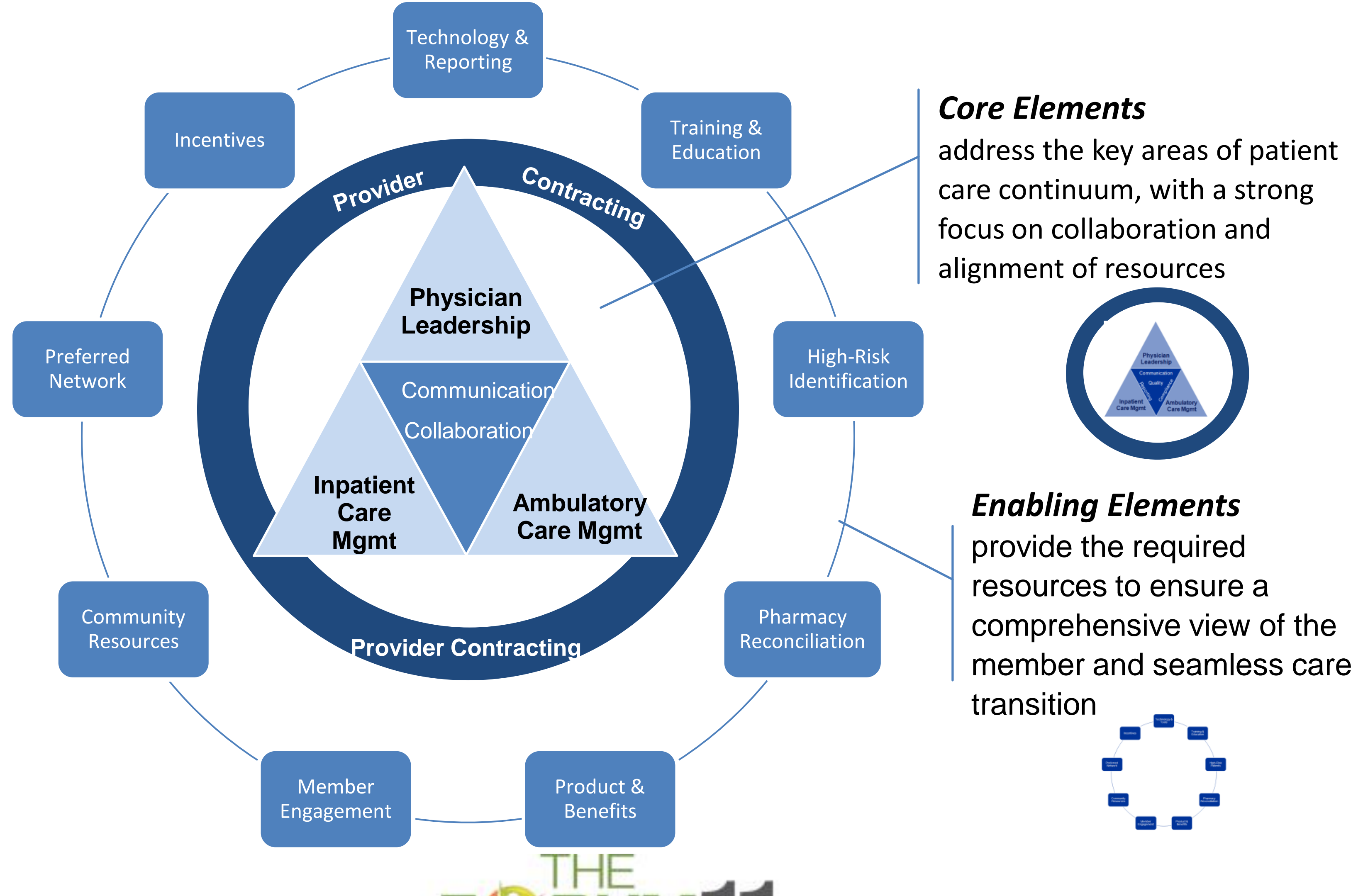
Medicare Advantage Care Management Vision

To ensure the success of MA in the future, plans will require a multi-faceted approach with several critical core components



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Medicare Advantage Care Management and Physician Collaboration Vision

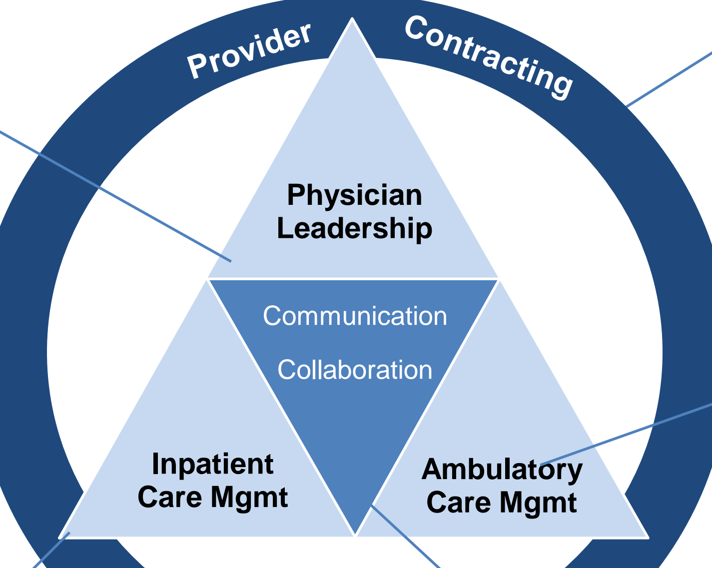
A new Medicare Advantage Medical Cost Management Operational Model is needed to keep plans and providers profitable

Physician Leadership

Requires a respected knowledgeable practicing physician leader who will work with the practicing physicians (in all settings) to define the best care alternative for the patient

Provider Contracting

Have to align the incentives and offer a sizeable upside for strong clinical and financial results – no matter the contracting vehicle selected



Ambulatory Care Mgmt

Provides case mgmt support for high risk members at home or in long term care to avoid costly acute IP admissions

Inpatient Care Management

Focus on transition of care post hospitalization rather than pure concurrent review

Communication, Collaborations & Quality

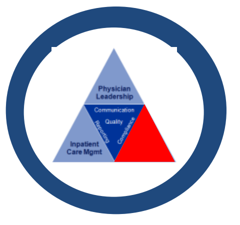
Requires an open dialogue on incentives and the requirements of a truly high quality intervention and on-line sharing of information (transparency)

Contracting

Incentives need to focus on gain sharing options and individual physicians need transparency into the impact of the gain sharing on their income

- Incentives for the IDN will vary significantly based on
  - The willingness of the group or IDN to take risk
  - Upside v. downside risk – it is hard to start with a significant downside
  - Note: Gain sharing in Medicare programs is usually based on sharing saving when medical cost is below the premium received from CMS
- Incentives for individual physicians need to be transparent
  - Compensation model must be very clear
  - Have to limit the complexity and number of factors
  - Team-based v. individual incentives – pros & cons to each
- Additionally, there are the following requirements to engage with TMP:
  - Participate in regular TMP Leadership meetings
  - Engage with TMP at Group Leadership meetings
  - Participate in two-way reporting, with providers referring cases to TMP, and receiving referrals from the health plan as well
  - Engage in care management (whether delegated or not)

Ambulatory Care Management



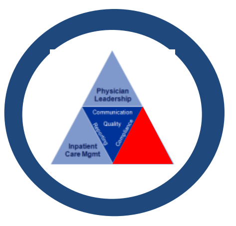
1. **Geriatric Content-** Meet specific population needs with specialized skills and program focus, including:
   a. Focus on geriatric conditions
      - Frailty/sarcopenia , Falls, dementia,
      - advanced Care Planning / prognosis and disease trajectory,
      - polypharmacy and adjustments to guideline-driven treatment)

   b. Focus on high Prevalence Conditions and Co-morbidities
      - COPD
      - CHF
      - CKD
      - DM
      - Sleep disorders
      - Arthritis

   c. Leverage Interdisciplinary geriatric support teams that incorporate as many elements of best practice programs as possible, borrowing from programs such as GRACE or HELP

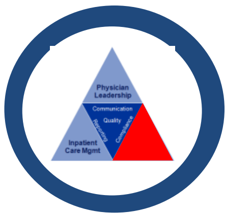
   d. Incorporate specific clinical skills to effectively communicate with home caregivers

Ambulatory Care Management



2. **Case Management Relationships with Providers –** implement a range of best practices to facilitate active provider engagement and implement structures to support collaboration across stakeholders
   a. Case review with Individual PCPs and CM
   b. Communication via e mail, EMR, phone
   c. Face-to-face with PCP when feasible
   d. Facilitate communication with the full range of stakeholders, including:
      – Home care agencies
      – SNFs
      – Hospital Case Management
      – Hospitalists
      – Hospice agencies
      – Community support agencies

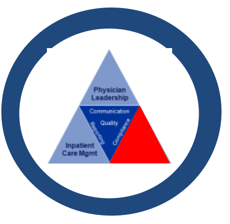
Ambulatory Care Management



3. **Predictive Modeling –** engage in analytics and behavioral economics to identify the members for whom intervention will have the greatest impact
    - Stratify population for stratified interventions
    - Likely to incur costs v. likely to reduce costs with interventions

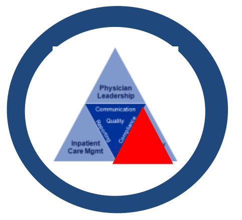
4. **Member Relationships –** use generalists to develop member centric relationships that meet full range of needs rather than disease focused interventions
    - Generalist CM for single point of contact with member
    - Back office supports to empower that generalist with specialist knowledge
        - Training
        - Physician support
        - Online decision support tools
        - Specialist skill sets
    - Coaching members
    - Face-to-face for some subsets

Ambulatory Care Management



5. **Proactive management to prevent admissions –** seek out management opportunities to get upstream of complications before they occur
   a) Predictive Modeling to identify highest risk and most “impactable” opportunities
   b) Complex member management, including coaching, transition of care support, and care coordination
   c) Chronic member management [aka Disease Management], focused on whole person approach
   d) Emergency Department avoidance strategies
      – Conduct retrospective review of ED visits, member re-education to keep geriatrics out of the ED unless completely necessary
      – Ensure expedited visits for members who are in Care Management and develop triggers for rapid intervention to avoid the need for ED

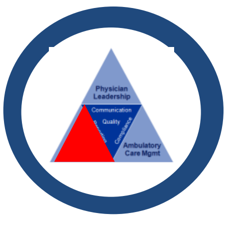
Ambulatory Care Management



6. **Caregiver supports** – support entire landscape to support care
   a. Coaching home care givers on how to provide critical support role
   b. Planning for how to continue care when there are absences of family care giver (e.g. business trips, vacations)

7. **Community Resources –** Leverage full scope of resources to support members, particularly those that providers may not have readily available
   a. Disease-based information (ADA, NKF, etc.)
   b. Association for Blind for low vision
   c. Alzheimer's Association
   d. Councils on Aging and other state level and community support (e.g. home health, meals of wheels)
   e. Nutritional resources
   f. Transportation
   g. Socialization
   h. Others

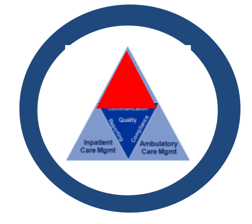
Inpatient Transition Care Management



- **Transitions management** – provide critical support to members in transitions out of hospital to SNF, home or other facilities, including:
  a. Pre-discharge education and assessments
  b. Tertiary repatriation into community
  c. Post-discharge follow-up call
  d. Medication reconciliation
  e. Caregiver engagement
  f. Cognitive assessment
  g. Pre-admission discharge planning
  h. Coordination with aftercare, specialists, home care
  i. SNF engagement
  j. Team meetings
  k. Discharge disposition assessment tools

Note, some challenges may include partnering with ED doctors to engage them around alternative resources for transitions. For some provider groups, a case manager in the ED can provide support on seeing patients and arranging after care

Physician Leadership

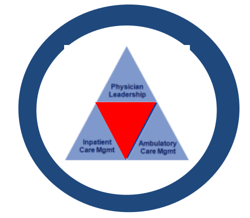


Having a physician leader for the effort who is well respected and willing to push appropriate transition of care is critical to the success of the program

Strong physician leaders are essential to support the success of the PCHM. Successful leaders will have the need to have abilities across leadership, data/information & incentivizing physicians . They will the following characteristics

- Ability & wiliness to hold physicians accountable, including having tough conversations, and leveraging insights from data to demonstrate outcomes
- Ability to have power / leadership over other physicians in the practice, even though they may not have formal reporting authority
- Ability to create an environment of continuous learning for physicians and make it easy for them to learn new skills to meet new challenges (e.g. diagnosing, documenting, member satisfaction, quality incentives)
- Ability to drive engagement and strong relationships with other stakeholders , and ability to confront stakeholders that need to be held accountable, including:
  - ED
  - Hospitalists
  - SNFs
  - Home Care

Information Sharing & Reporting



Timely information of quality and utilization is key, with a future goal of providing this information at the point of care.

Group performance on multiple metrics:

- Cost
- Utilization
- Quality
- Diagnosing, Documenting, and Coding
- Membership

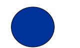
- Comparisons to Norms, Benchmarks, and Goals- including risk-adjusted variances from targets
- At multiple levels of aggregation
  - IDN
  - Group
  - PCP (and in some cases, specialist)
  - Member
- The goal of reporting and information sharing is to identify and share best practices, and consider how to replicate in different settings
- Reporting should include:
  - Retrospective reporting (but as real-time as possible)
  - Prospective reporting based on predictive algorithms for missed diagnoses, conditions, severity – work towards gaps on care at the point of care
  - Concurrent review to identify transition management opportunities and provide just in time information to close gaps in care

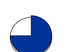
Physician Group Performance to Best Practice Model

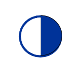
There is a strong (but not exact) correlation between best practices and financial performance.

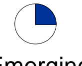
	D	B	F	E	G	C	A1	A2
Membership	**6,687**	**14,038**	**3,408**	**4,134**	**2,441**	**9,358**	**17,759**	**4,705**
Incentives	Leading	Emerging	Advanced	Established	Emerging	Advanced	Emerging	Emerging
Physician Leadership	Leading	Emerging	Advanced	Established	Emerging	Established	Established	Emerging
Care Management – In Patient	Leading	Established	Advanced	Advanced	Emerging	Emerging	Established	Emerging
Care Management – Ambulatory	Leading	Established	Established	Established	Established	Emerging	Emerging	Emerging
Reporting	Leading	Established	Emerging	Established	Established	Emerging	Established	Emerging
PMPM performance against benchmark*	**$127.23**	**$29.90**	**$22.55**	**$14.14**	**($5.82)**	**($6.51)**	**($13.60)**	**($15.38)**

** Based on the Northeast lightly managed MA external benchmark; a **negative** value indicates **poor** performance (opportunity for improvement)*


Leading


Advanced


Established



Emerging

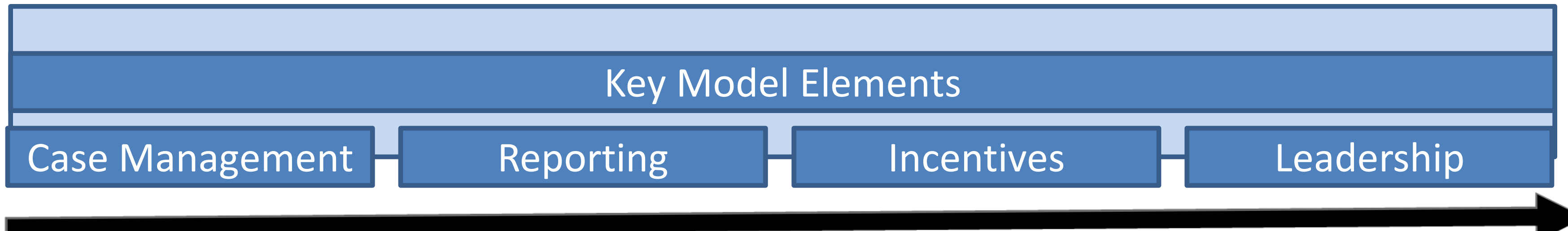
Customized Solutions

No two physician groups have the same capabilities and culture and the Heath Plan has to decide how far is it willing to go to support the partnership

- Health Plans have a choice:
  - Only contract with groups that have these factors. Forgo membership linked to groups that lack them

OR

  - Develop supports that tailor to the needs of the groups with variable success and at the cost of customized contracts and customized supports



Easier for health plan to provide support to provider groups

More difficult for health plan to provide support to provider groups

Health Plans can tailor their support to meet the needs of the provider group

Customized Solutions – Model Continuum

The Heath Plan may have to modify the model for each group and has to decide how far is it willing to go and where does it make financial sense to do so

Model Continuum

Well performing full-risk delegated group

- Medical group accountable for care management components and related funding
- Meets targets independently
- Payor provides standardized oversight

Shared risk group with some improvement opportunities

Shared risk group with significant improvement opportunities

High degree of variability in group structure, performance and level and type of THP support.

Group where payor holds all risk

- Payor accountable for all care management components and related funding

IDN Driven Model

Partially Supported Model

Heavily Supported Model

Payor Driven Model

Current network comprises many unique medical cost management arrangements and wide variability in groups' capabilities and willingness to engage in change.

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