



Patient-Centered Medical Home





















PROTECT PROMOTE IMPROVE



Healthcare Transformation in Ohio

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Healthy Ohio Business Council Meeting

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Ohio's Health System Performance

Health Outcomes – 42nd overall¹

- 42nd in preventing infant mortality (only 8 states have higher mortality)
- 37th in preventing childhood obesity
- 44th in breast cancer deaths and 38th in colorectal cancer deaths

Prevention, Primary Care, and Care Coordination¹

- 37th in preventing avoidable deaths before age 75
- 44th in avoiding Medicare hospital admissions for preventable conditions
- 40th in avoiding Medicare hospital readmissions

Affordability of Health Services²

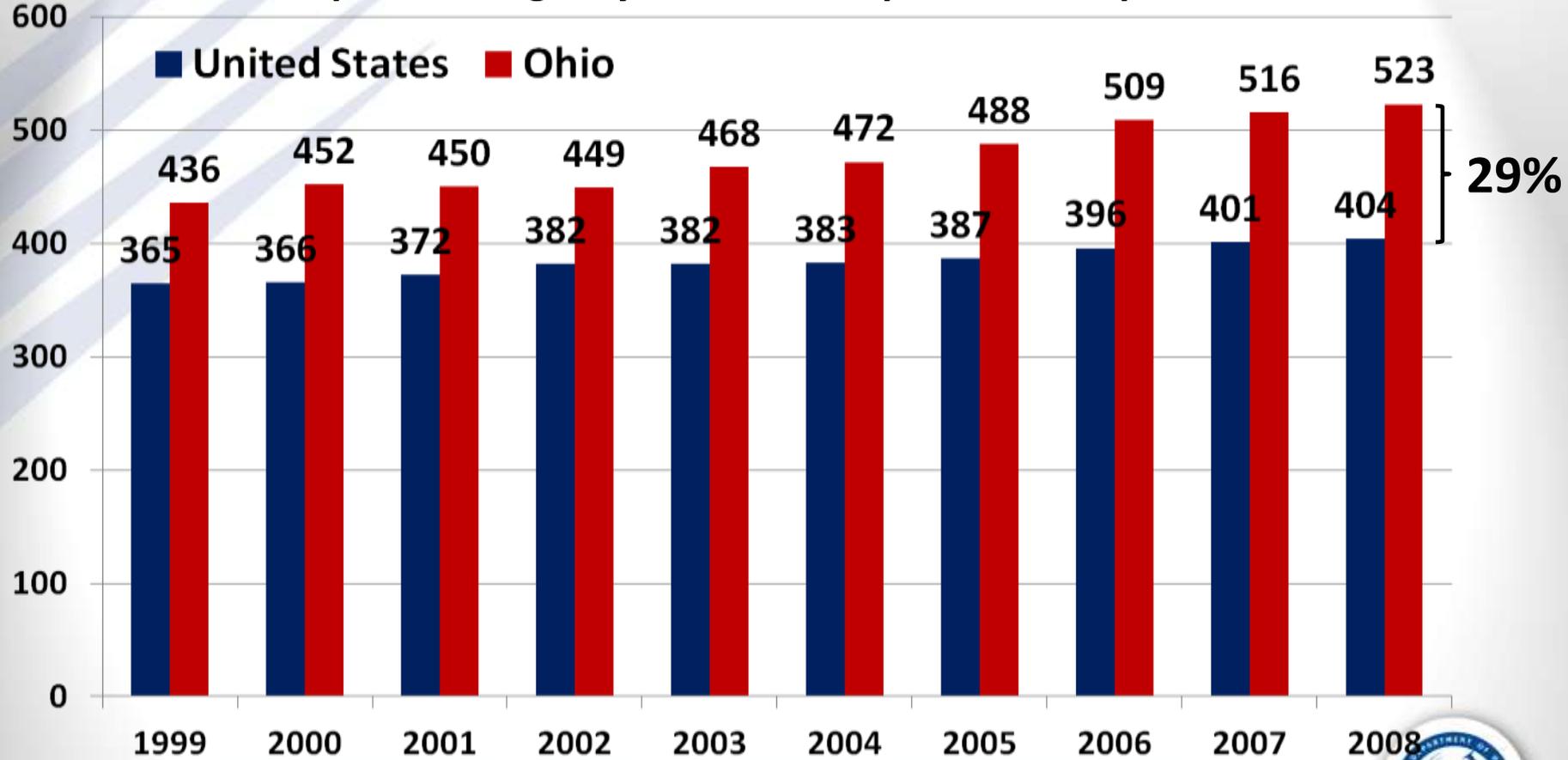
- 37th most affordable (Ohio spends more per person than all but 13 states)
- 38th most affordable for hospital care and 45th for nursing homes
- 44th most affordable Medicaid for seniors

Sources: (1) Commonwealth Fund 2009 State Scorecard on Health System Performance
(2) Kaiser Family Foundation State Health Facts (updated March 2011)

Medical Hot Spot:

Emergency Department Utilization: Ohio vs. US

Hospital Emergency Room Visits per 1,000 Population



Governor's Office of Health Transformation

Source: American Hospital Association Annual Survey (March 2010) and population data from Annual Population Estimates, US Census Bureau:
<http://www.census.gov/popest/states/NST-ann-est.html>.



Fragmentation

vs. Coordination

- Multiple separate providers
- Provider-centered care
- Reimbursement rewards volume
- Lack of comparison data
- Outdated information technology
- No accountability
- Institutional bias
- Separate government systems
- Complicated categorical eligibility
- Rapid cost growth

- Accountable medical home
- Patient-centered care
- Reimbursement rewards value
- Price and quality transparency
- Electronic information exchange
- Performance measures
- Continuum of care
- Medicare/Medicaid/Exchanges
- Streamlined income eligibility
- Sustainable growth over time

Office of Health Transformation (OHT)



Health Transformation Priorities

- Improve Care Coordination
- Integrate Behavioral/Physical Health Care
- Rebalance Long-Term Care
- Modernize Reimbursement
- Balance the Budget



Health Transformation Priorities

- Early Child Programs
- Housing
- Health Information Exchange
- Workforce Workgroup
- Balance the Budget



Patient-Centered Medical Homes



Patient-Centered Medical Homes

- Primary Healthcare Provider
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety are Hallmarks
- Enhanced Access
- Payment for Value



PCMH Outcomes

Primary care patient-centered medical home results in:

- Improved quality of care and patient experiences.
- Reduced cost from hospital and emergency department utilization.



Cost of Chronic Care in the U.S.

The main cost drivers of health care are individuals with chronic conditions¹

- 5% of beneficiaries account for 43% of Medicare spending
- 25% account for 85% of total spending

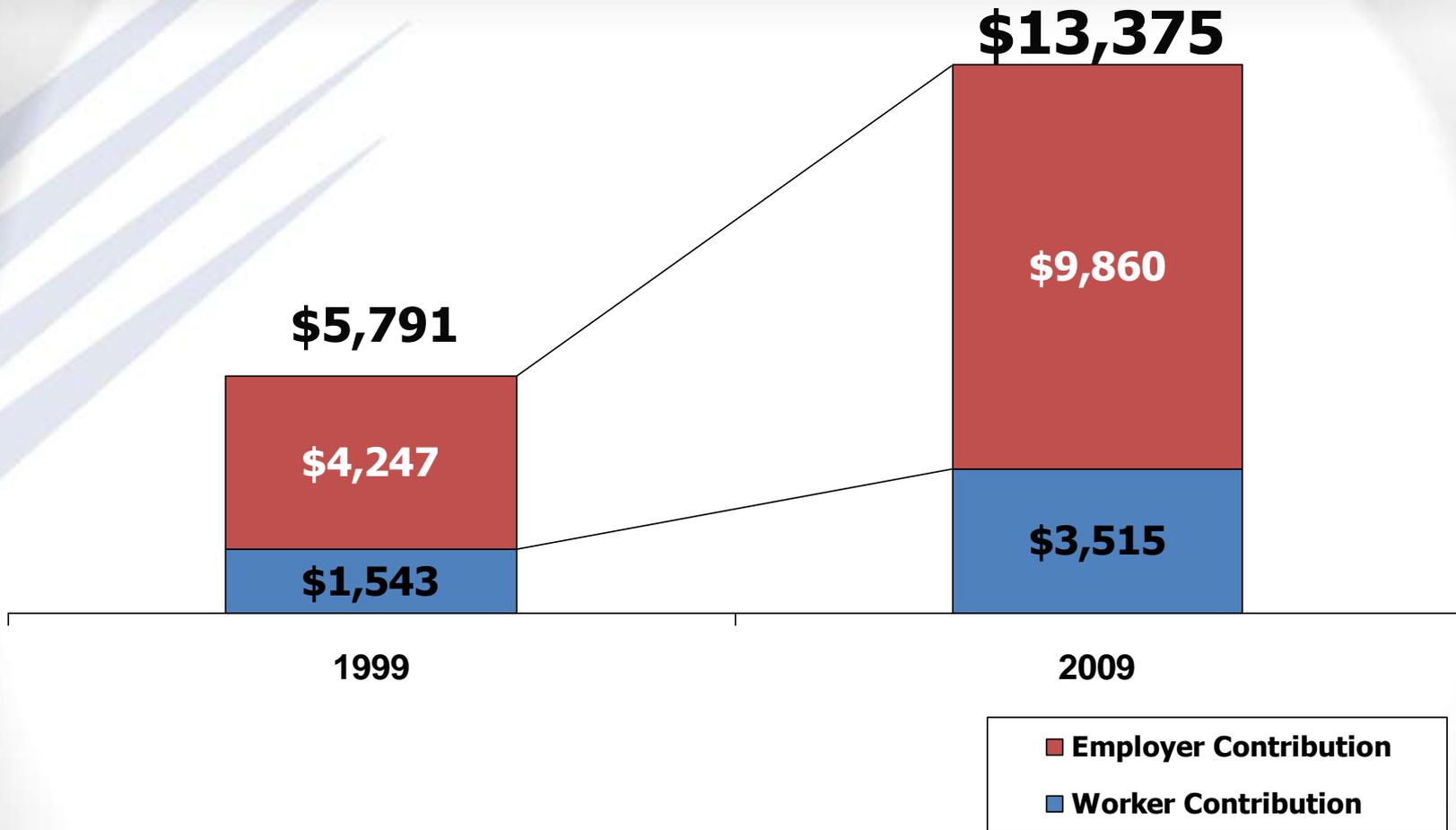
Costs are driven by fragmentation and inefficiency

- 27% of Medicare patients discharged with a diagnosis of chronic heart failure were re-admitted within 30 days²
- 50% of patients discharged with any medical diagnosis, who were readmitted within 30 days had no outpatient visit during the intervening time³



1. Congressional Budget Office. High-Cost Medicare Beneficiaries. 2005. www.cbo.gov/ftpdocs/63xx/doc6332/05-03-MediSpending.pdf. Accessed July 8, 2009
2. Jencks SF, et al. *N Engl J Med*. 2009;360:1418–1428.
3. Ibid.

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

How PCMH Helps

Currently, in the United States, only 4% to 6% of total health care expenditure is for primary care.^{1, 2}

However, there is demonstrable positive impact:³

- Adults who have an established relationship with a primary care physician had 33% lower costs of care, and were 19% less likely to die

The movement toward patient-centered medical homes (PCMH) builds and improves on the current efficiency and quality of primary care practices.



1. Goff V. *Rebuilding our Primary Care Infrastructure*. June 2009. National Business Group on Health.
2. Machlin, SR. and Carper K. *Expenses for Office-Based Physician Visits by Specialty, 2004*. Statistical Brief #166. March 2007. Agency for Healthcare Research and Quality, Rockville, Md.
3. Starfield B, Shi L. *Pediatrics*. 2004;113:1493–1498.

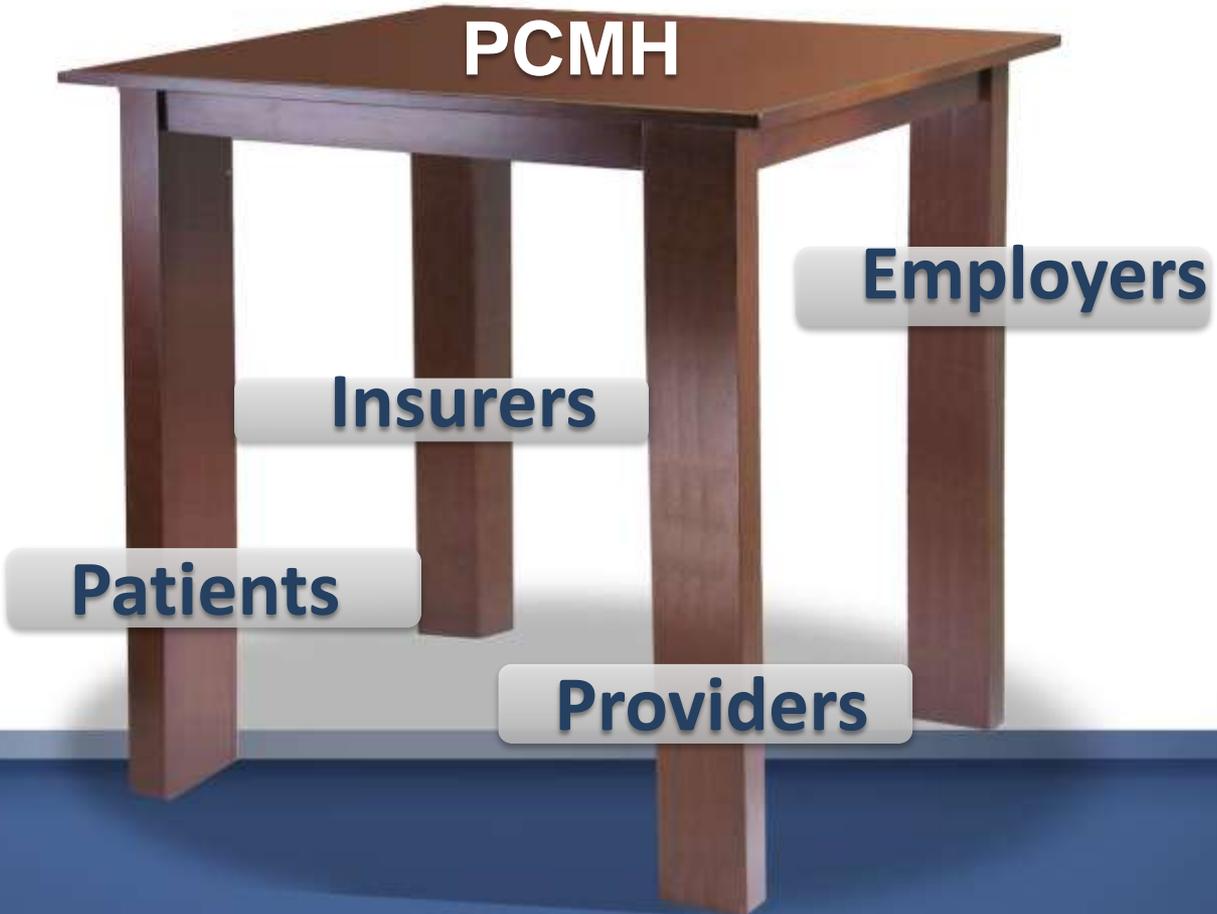
Blended Reimbursement



Value-Based Insurance Design

- Pay for what you want
 - Value-based, not volume-based reimbursement
- Three Principles of VBID¹
 - 1) Value = the clinical benefit achieved for the money spent.
 - 2) Healthcare services differ in the health benefits they produce.
 - 3) The value of healthcare services depends on the individual who receives them.





PCMH

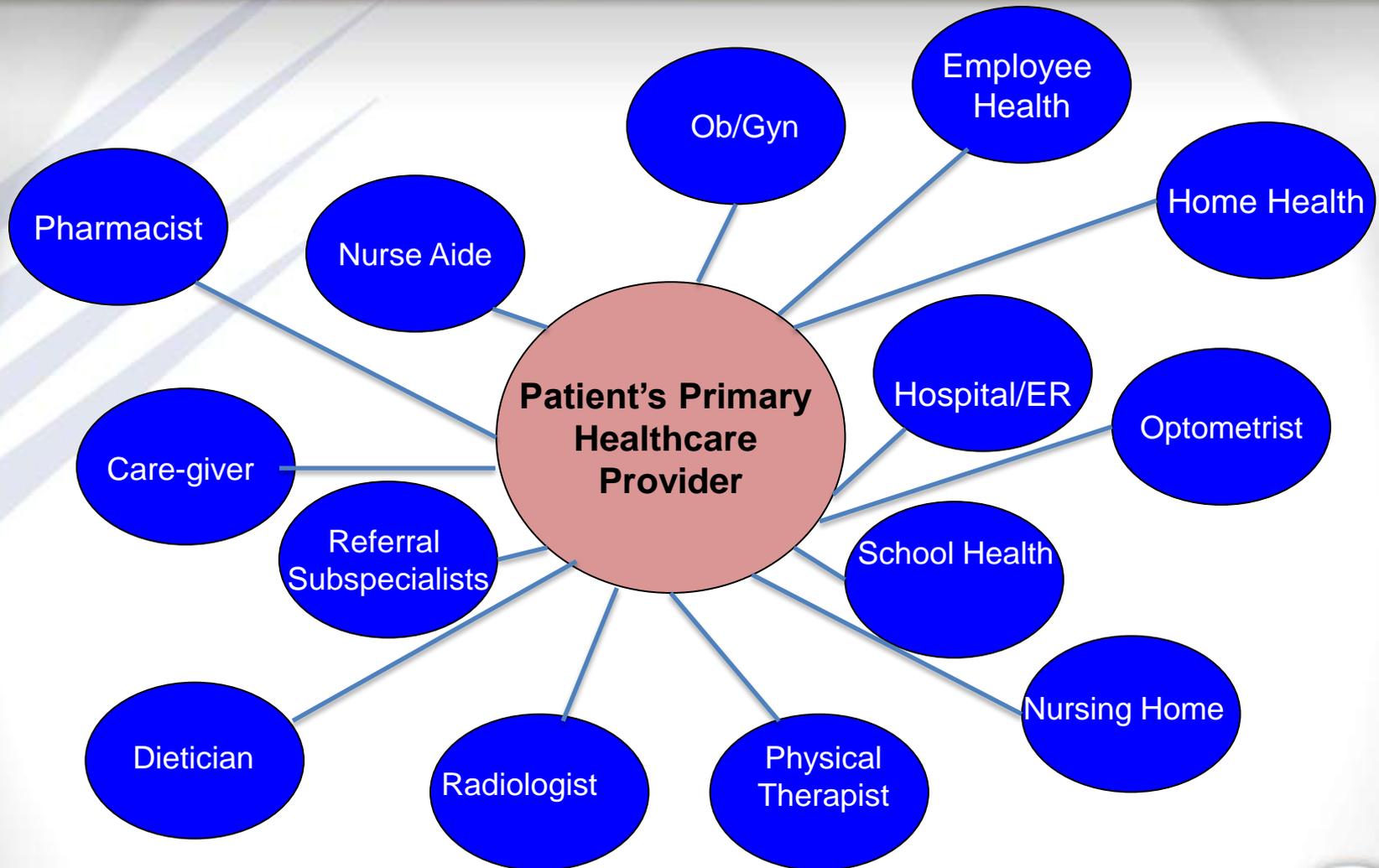
Employers

Insurers

Patients

Providers

Medical Neighborhood



National PCMH Initiatives

- ▶ All Military: Army, Navy, Air Force, Marines
- ▶ U.S. Department of Veterans Affairs
- ▶ Meijer
- ▶ Caterpillar, Inc.
- ▶ Walmart
- ▶ Several Fortune 100 companies



U.S. AIR FORCE



Marines



NCQA Recognized – Level 1



* As of 12/1/2011

NCQA Recognized – Levels 1 & 2



NCQA Recognized – Levels 1, 2 & 3



House Bill 198

Ohio Patient-Centered Medical Home Education Pilot Project

- 44 total practices, 4 medical schools & 5 nursing schools
- Charge from **HB 198**
 - Loan Repayment
 - Reimbursement Reform
 - Curriculum Reform



NCQA Recognized + HB 198 Sites



* As of 12/1/2011

Regional View – Cleveland

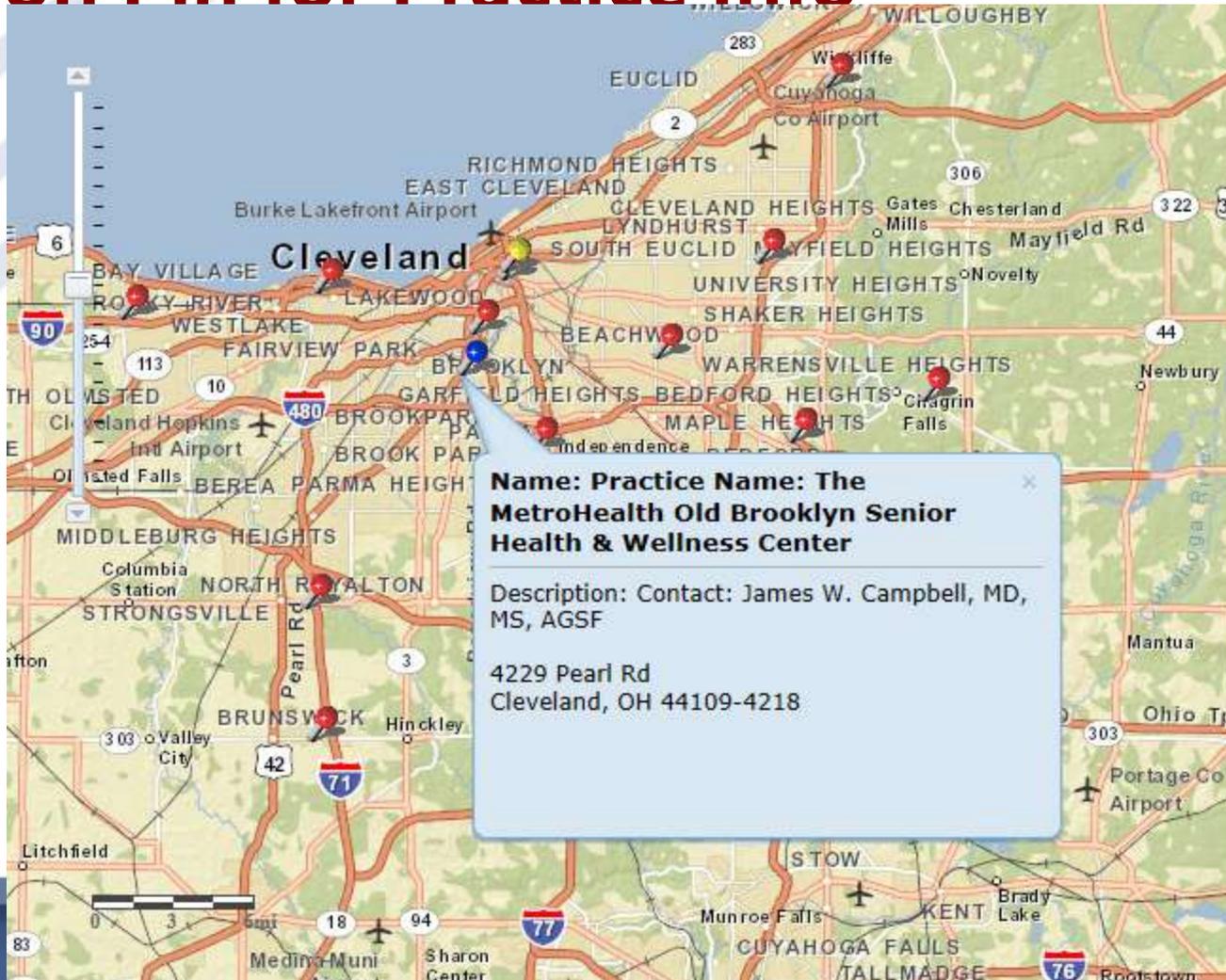
NCQA Recognized + HB 198 Sites



* As of 12/1/2011

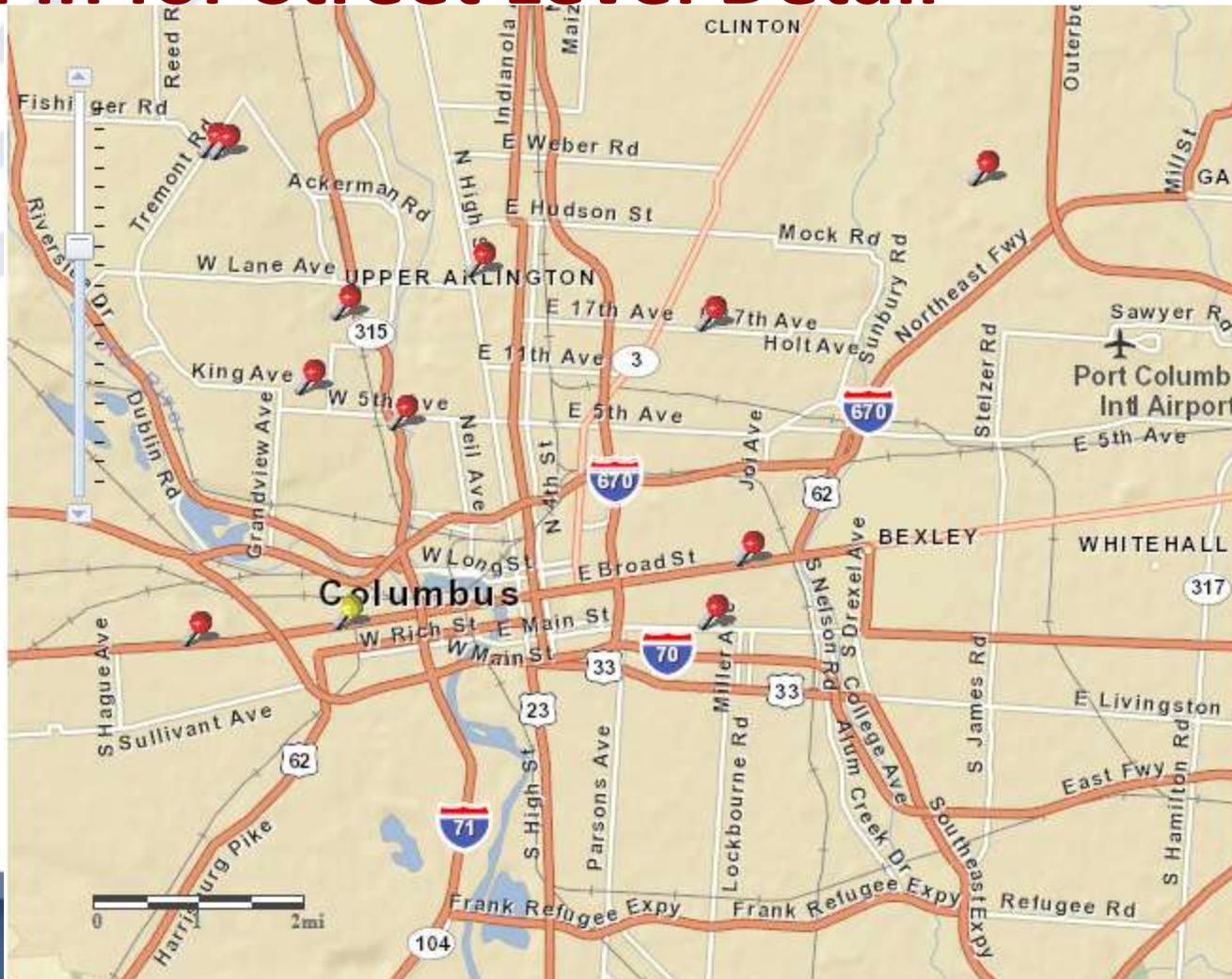
Regional View – Cleveland

Click on Pin for Practice Info

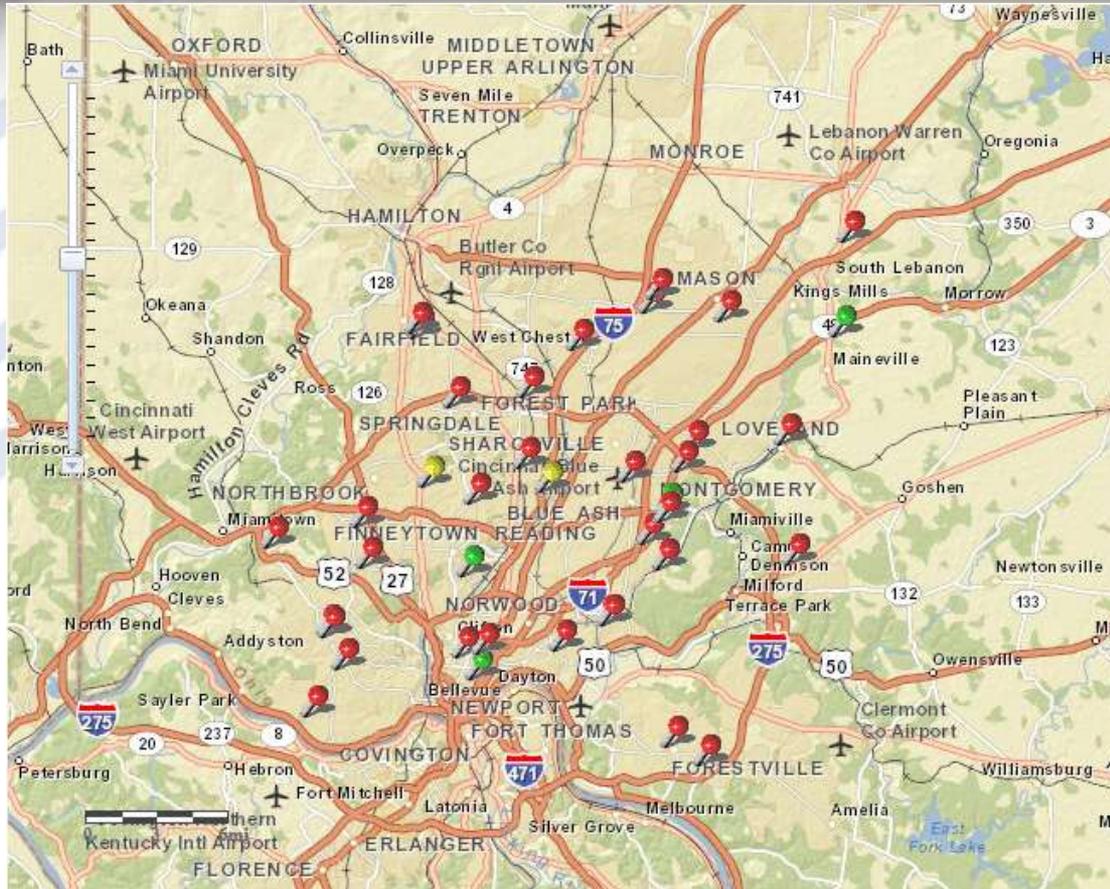


Regional View – Columbus

Zoom in for Street Level Detail



Regional View - Cincinnati



To search for PCMH in Ohio maps : www.odh.ohio.gov, click on “Healthcare Providers.”



Medicaid Health Home

For Medicaid, the PCMH model of care is called the Health Home and its core components are from Section 2703 of the Affordable Care Act (ACA).

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including follow-up from inpatient to other settings
- Patient and family support
(including authorized representatives)
- Referral to community and social support services, if relevant
- Use of health information technology to link services, as feasible and appropriate

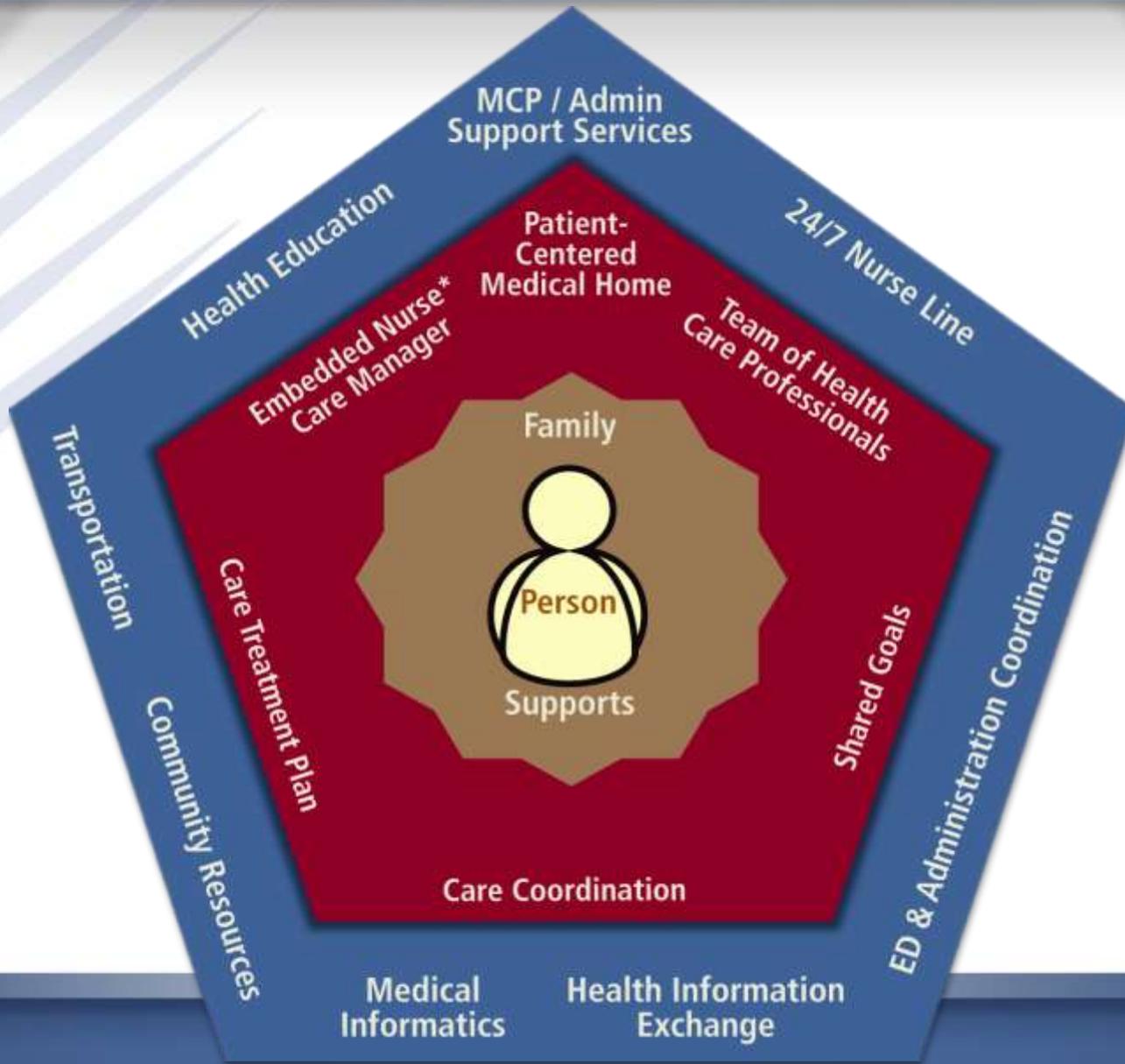


Medicaid Health Home

- Adds another payer for PCMH reimbursement/sustainability
- \$47 million over biennium (2012-2013)



Medicaid Health Home Service Delivery Model



CMMI Comprehensive Primary Care Initiative

5-7 markets nationally will be selected, with no more than 2 markets chosen out of our region (Ohio, Illinois, Indiana, Michigan, Minnesota, and Wisconsin)



CMMI Comprehensive Primary Care Initiative

4 year Initiative

Medicare

\$8-\$40 risk adjusted (\$20 average) PBPM global support in addition to traditional FFS

Shared Savings disseminated according to quality measures in years 2-4 of the Initiative

Medicaid

State participation with similar PBPM global support/no shared savings

Private Insurers

CMMI looking for numerous payers to mirror the new Medicare payment structure



Patient-Centered Primary Care Collaborative (PCPCC): Just a Few of the Members

Cleveland Clinic

General Mills, Inc.

General Motors

Johnson & Johnson

Microsoft

Ohio Department of Health

Pfizer

Procter & Gamble

The Dow Chemical Co.

United Healthcare

Xerox



Joining PCPCC

- Go to www.pcpcc.net
- Click on “Join and Support”
- Fill out online form

No cost for general membership.



Contact Information

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Today's presentation is available at:

<http://www.healthyohioprogram.org/businesses/businesses.aspx>

