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Policy Studies in Family Medicine and Primary Care

The Impact of Primary Care Practice Transformation on Utilization, Cost and Quality

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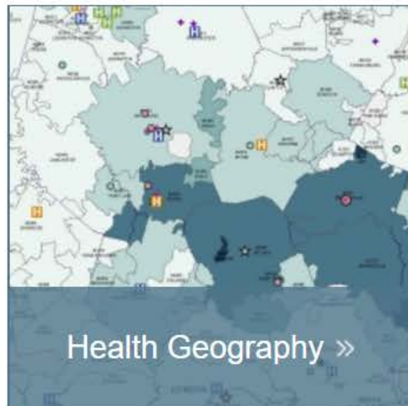

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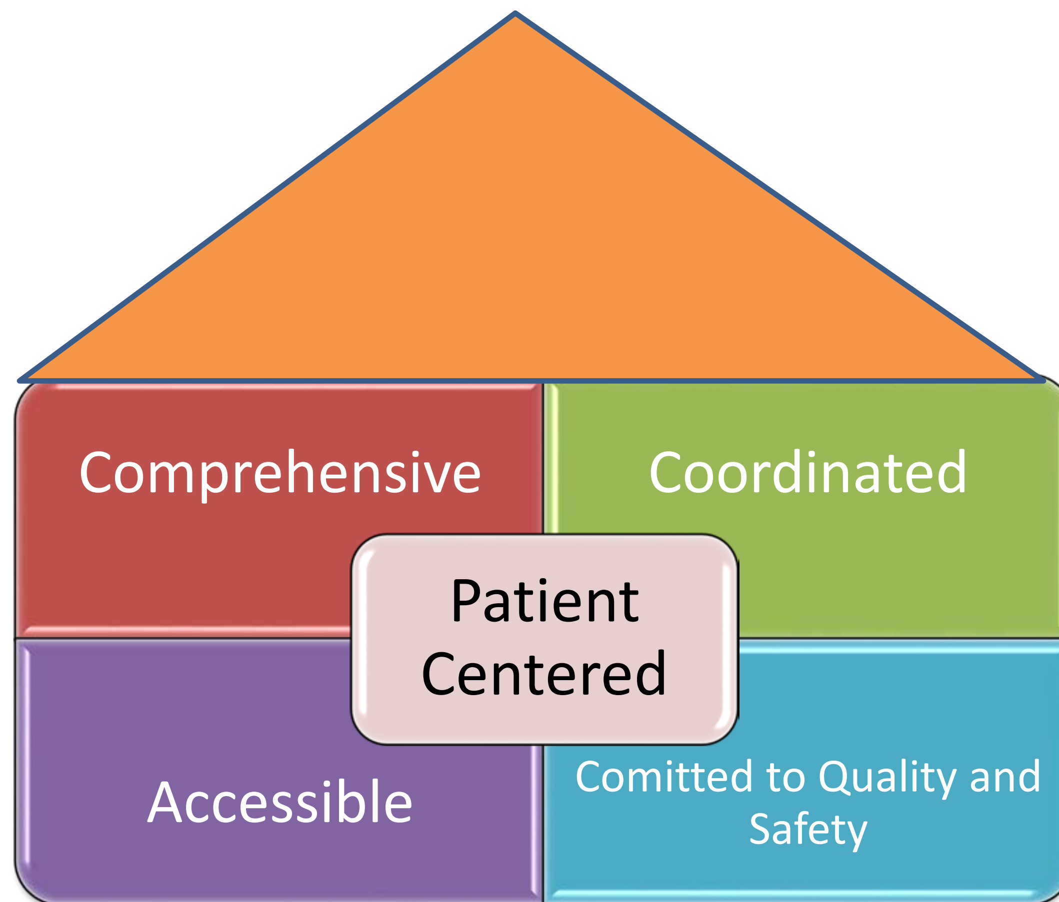
The Patient Centered Medical Home



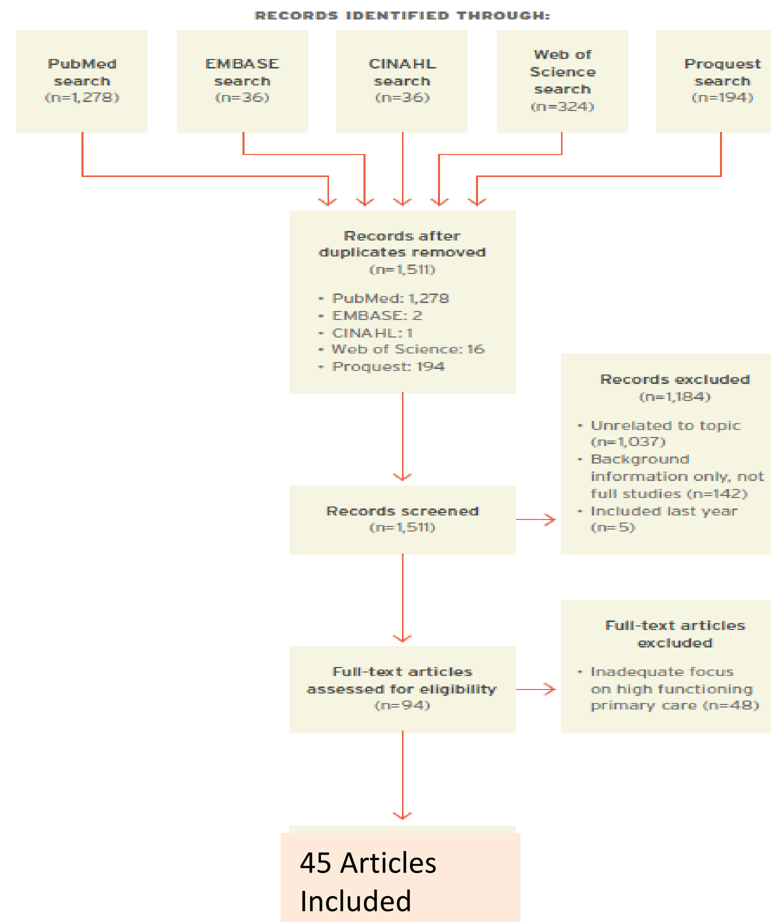
Our Task

- Review of the literature published about the PCMH and advanced primary care in 2016
- Focus on Cost, Utilization and Quality

What's Different this Year

- New authors
- Broader Scope of Research
- More rigorous search criteria
  - Peer- reviewed literature(45)
  - Grey Literature with a rigorous methods section

Literature Review Approach



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- PCMH Implementation Studies (17)- *PCMH vs. traditional care.*
- Features of PCMH Care Delivery Studies (15)- *Non-PCMH or not mentioned if PCMH but with PCMH like features as compared to traditional care.*
- PCMH Enhancement Studies (13)- *Mature PCMH's that study the impact of specific PCMH components(i.e.) team based care, telehealth)*

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Summary of Outcomes: Peer Reviewed Articles

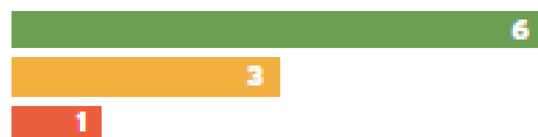
Number of articles reporting: Positive results · Mixed results · Negative results

Cost (n=13)

Quality (n=24)

Inpatient Utilization (n=6)

ED Utilization (n=10)



PCP Utilization (n=7)

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Peer Reviewed Studies-Cost

Type of Study	Results
PCMH Implementation Study (7)	Overall positive results • Increased savings over time and with more chronic conditions
Features of PCMH Care Delivery Study (1)	Negative • Only one study and limited patient population
PCMH Enhancement Study (5)	Overall positive results • Decreased in 3 studies, unchanged in 2

Type of Study	Results
PCMH Implementation Study (7)	Mixed
Features of PCMH Care Delivery Study (10)	Mixed
PCMH Enhancement Study (8)	Mixed with a trend towards positive*

All 3 studies looking at the patient experience reported positive findings

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Peer Reviewed Studies- Utilization

Type of Study	Results
PCMH Implementation Study (11)	Mixed • Those that reported on PCP visits showed increases • Many but not all decreased ED visits • Only 1 of 11 studies showed a decrease in inpatient hospitalization
Features of PCMH Care Delivery Study (7)	Mixed • Those that reported on PCP visits showed increases • Many but not all decreased ED visits • No difference in the studies that looked at inpatient
PCMH Enhancement Study (7)	Mixed, trend towards positive

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VA-PACT Spotlight

Program Name	Intervention	Utilization	Cost	Quality
H-PACT vs PACT	Increased access to care with open-access, walk-in capacity, flexible scheduling, outreach to homeless veterans, on site community programs (food, hygeine); intensive health care management with care managers;	Higher utilization of outpatient services 19% reduction in ED visits and 34.7% reduction in hospitalizations pre/post intervention		
Im-PACT vs PACT	Intensive outpatient Program: multidisciplinary team, comprehensive patient assessment, tracking of patient goals, care management, frequent contact, community interventions, weekly team discussions of high risk patient	Increased PCP visits. No change in inpatient or ED utilization	Significant increase in monthly person-level primary care cost	No significant difference in mortality Increased patient satisfaction
EQBI-PACT Vs PACT	Evidence based quality improvement	EBQI-PACT had decrease mean primary care encounters and increases in mean telephone care encounters	No difference	EBQI-PACT had higher use of secure messaging and higher rates of contact after discharge compared to PACT-only sites.

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FIGURE 1

Program Spotlight: Michigan Blue Cross Blue Shield

Blue Cross Blue Shield of Michigan has the largest and longest running Patient Centered Medical Home. A key to their success, as outlined here, has been using lessons learned from other advanced primary practices" as the building blocks" for their practice transformation.

LESSON #1

Nurture effective and stable leadership

The Physician Group Incentive Program (PGIP) has catalyzed the formation of over 40 Physician Organizations (POs) that have led and supported practices in revolutionizing the delivery of health care in Michigan.

LESSON #2

Gather together (get everyone around the table)

BCBSM's facilitation of quarterly meetings with all PO leaders (approximately 350) has led to cross-collaboration and synergistic partnerships among providers across the state, as well as the formation of a Primary Care Leadership Committee that provides review and guidance on PGIP policies and programs.

LESSON #3

Spark physician enthusiasm

"Relentless incrementalism" is a PGIP motto, and PGIP initiatives are designed to support and reward step-by-step progress through the celebration of provider and program best practices at quarterly meetings.

LESSON #4

Demand federal commitment, action and coordination

PGIP medical leaders have testified before Congress regarding the value-based reimbursement model and the importance of the federal government supporting and recognizing regional practice transformation efforts.

LESSON #5

Offer meaningful financial support

The PGIP program has used a combination of incentive reward payments to POs and value-based reimbursement for individual physicians to ensure providers have the financial support needed to succeed.

LESSON #6

Encourage multi-payer participation

The PGIP program provided the foundation for the five year Michigan Multi-Payer Advanced Primary Care Practice Demonstration program.

LESSON #7

Offer technical assistance and collaborative learning

PGIP provides practices with technical assistance and opportunities for collaborative learning by hosting learning collaboratives, providing education and guidance and funding a Care Management Resource Center.

LESSON #8

Embrace team-based approaches that extend beyond the practice

POs and practices deliver multi-disciplinary team-based care through access to a Provider-Delivered Care Management (PDCM) program, behavioral health providers and embedded pharmacist care managers.

LESSON #9

Establish realistic time tables for evaluation

Underlying the PGIP philosophy of relentless incrementalism is the understanding that practice transformation is a long-term process, and programs must be allowed to stabilize and mature before results are evaluated.

LESSON #10

Obtain timely, accessible and useful data

The PGIP PCMH/PCMH-N program provides financial support to POs and practices to build the capacity for population management through use of integrated patient registries and performance reporting.

Comprehensive Primary Care Initiative (Year 3 report)

- 4 year multi-payer initiative started in 2012
- Included 7 US regions
- Offered population-based care management fees and shared savings to support core primary care functions

Multi-Payer Advanced Primary Care Practice

(Year 3 report, thematic analysis)

- 3 year multi-payer initiative started in 2011
- Began with 8 states, 5 of the 8 continued through 2016
- Offered a monthly care management fee for beneficiaries in advanced primary care practices

CPCI Results

	Year 1	Year 2	Year 3
Cost (Without care management fees)	Decreased by 2%***	Decreased by 1%	No net savings . Increased cost in Ohio/Kentucky**
Utilization			
ED	Decreased by 1%	Decreased by 1%	Decreased by 2%***
Hospitalizations	Decreased by 2%	Decreased by 2%	Decreased by 1%
Quality (Urine protein testing in diabetics)****	Increase by 0 .7%	Increase by 1 .6%***	Decrease by 0 .1%

**Shared-savings calculations (different than the evaluation) showed savings in Arkansas, Colorado, Oklahoma and Oregon .
*** Statistically significant result . All other reported results not statistically significant to P values < 0 .05% .
**** Among quality of care process measures urine protein testing in diabetics was the only measure that showed a statistically significant change

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Comprehensive Primary Care Initiative

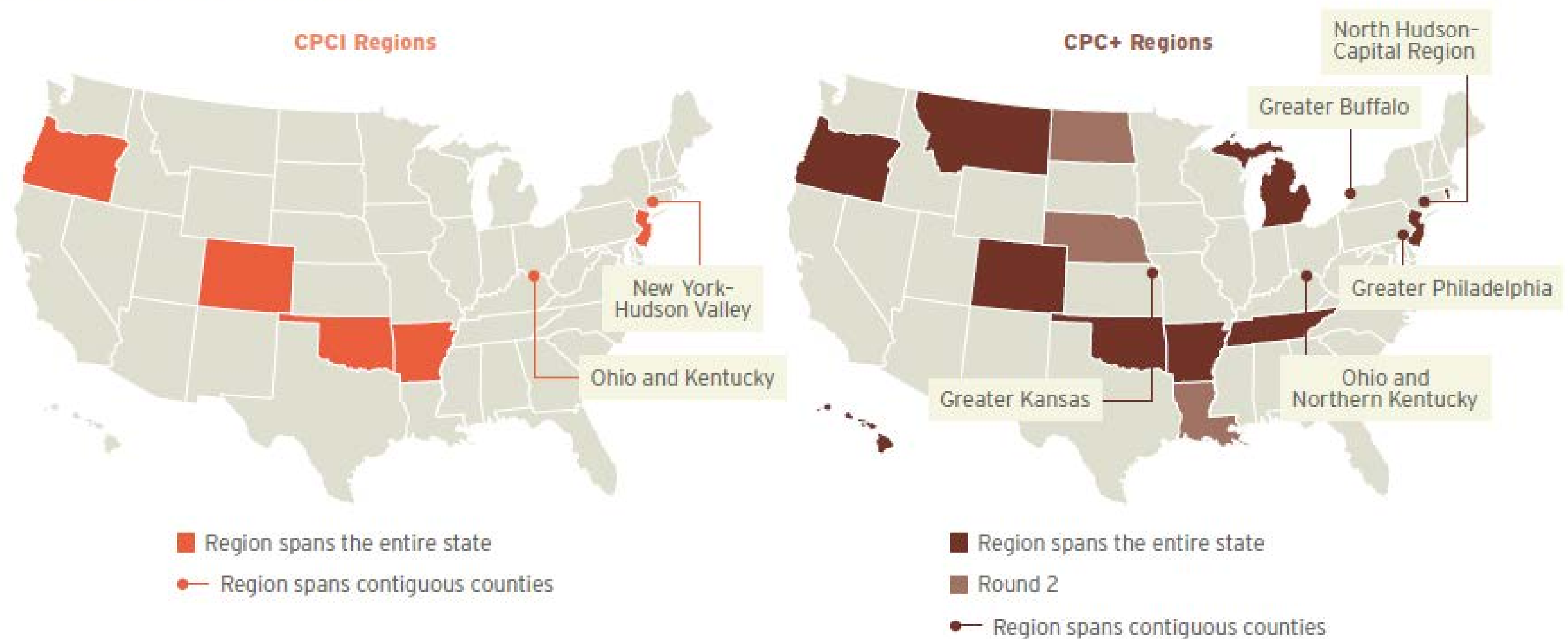

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FIGURE 8
STATE SPOTLIGHT
Colorado

Program Name
Accountable Care Collaborative

Program Description
1) Created seven regional care collaborative organizations (RCCO's) that are responsible for coordinating patient care and connecting members with non-medical services 2) Primary care medical providers (PCMPs) contract with RCCO's to become medical homes for Medicaid members in the collaborative. 3) RCCOS's and PCMP's receive incentive payments based on performance on key metrics

Payment for Programs
CPCI funding, Medicaid and Grant funding

Program Outcomes
Cost: Reduced costs about $60 per member per month (PMPM) on adults and $20 PMPM on children as compared to eligible members who were not enrolled in an ACC over the same time period. In dual eligible beneficiaries this cost savings was about $120 PMPM. *

Utilization: well child checks for children ages 3-9 increased from 20.6% for clients who were enrolled less than 6 months to 43% for those enrolled for 7 months or more. They also found that follow up care after hospital discharge increased from 41.2% to 49.4% the longer the patient was enrolled in the program. As time enrolled in the program increased, utilization of ER services decreased by 5% and 30 day all-cause readmissions decreased. **

Quality: No difference in key performance indicators

* Cost savings even shown when controlling for CPCI and grant funding
** Significance testing not done or not reported

FIGURE 11
STATE SPOTLIGHT
Oregon

Program Name
Patient Centered Primary Care Home

Program Description
1) Provide financial support for practice transformation 2) Identify and disseminate best practices of a medical home 3) encourage individuals who are covered by Oregon's Health Plan to enroll in PCPCH clinics

Payment for Program
CPCI funding and Medicaid

Program Outcomes
Cost: Reduced total service expenditures per person by 4.2%, apx $41 per person per quarter

Utilization: Increase in primary care and pharmacy services, and a reduction in all other service types. Of these, only total, specialty and inpatient care decreases were statistically significant

Quality: Not mentioned

MAPCP Results

Results:

- Thematic in nature
- Care management had most significant impact on utilization and expenditures
- Reaching out to recently hospitalized patients important
- Risk stratifying and allocating resources also important

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MAPCP State

FIGURE 10
STATE SPOTLIGHT
Minnesota

Program Name
Health Care Home Initiatives (HCHI)

Program Description
1) Provide financial incentives for clinics to transform 2) Developed a learning collaborative for participating clinics 3) Developed certification standards and transformation assistance

Payment for Program
MAPCP

Program Outcomes
Cost: Demonstrated significant savings on their Medicare, Medicaid and Dual eligible beneficiaries as compared to non-healthcare home patients in the same time period

Utilization: 1) Increase in emergency department and skilled nursing home use relative to non-Health Care Homes. 2) Significant decreases in the use of inpatient hospital services. 3) Slight decrease in the use of prescription drugs. 3) Decreased hospital based outpatient visits* 4) Increase in office based outpatient visits

Quality: 1) better adjusted quality of care for patients with diabetes, lipid screening, asthma, depression and colorectal cancer screening 2) The largest and most significant findings were in optimal asthma care 3) Patient experience was unchanged

* Generally more expensive visits and usually comprise of specialty visits rather than primary care visits.

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The analysis shows positive overall results in terms of cost, quality and utilization but not always uniformly

- Patients with greater comorbidity and systems with these patients may show greater early strides
- Transformed and transforming practices need time to mature before significant improvements can be achieved.
- We can’t apply a one-size- fits-all approach to the implementation and evaluation of practice transformation
- Mixed results seen in this review may be due to a positive spill- over effect of transformed practices on practices that have yet to transform.

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Thanks!

Questions? Comments?

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https://www.pcpcc.org/resource/impact-primary-care-practice-transformation-cost-quality-and-utilization