The Medical Home: The Cure for What’s Ailing Health Care

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Agenda

• What is a medical home?
• Fee for service programs—PCMH
• Ambulatory ICU
• Work-site clinics
• Monthly payment model—Direct Primary Care
• Opportunities and challenges for employers
The Crisis in American Healthcare

Cost

Overuse of unproven therapies, poor management of chronic conditions, fragmented care leading to gaps in care & missed opportunities

Access

Primary care workforce may be too small to meet everyone’s needs; long waits and short appointments are the norm

Many efforts to trim costs & change patient behavior → may get to 0% trend BUT what about the 30% unnecessary care delivered according to the IOM?
The Solution: Resuscitate Primary Care

- Advanced Care
- Administrative Overhead
- Primary Care

17% GDP & climbing

10-12% GDP & stable
What is a Medical Home?

• One provider/team as 1st point of contact for all care
• Most services received from that organization
• Care outside the “home” coordinated by provider team
• Focus on prevention & proactive health management
• Medical home accountable for outcomes and cost
• More focused on patient needs and wants rather than provider’s
## Types of Medical Homes

<table>
<thead>
<tr>
<th>Patient-Centered Medical Home</th>
<th>Worksite Clinic</th>
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<tbody>
<tr>
<td>- Fee-for-Service</td>
<td>- Occupational health</td>
</tr>
<tr>
<td>- Additional payments for enhanced services</td>
<td>- Prevention &amp; Wellness</td>
</tr>
<tr>
<td></td>
<td>- Some doing primary care</td>
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<table>
<thead>
<tr>
<th>Ambulatory ICU</th>
<th>Direct Primary Care</th>
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</thead>
<tbody>
<tr>
<td>- Focused on most complex &amp; costly patients</td>
<td>- Monthly fee</td>
</tr>
<tr>
<td></td>
<td>- All patient types</td>
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</table>
Fee for Service Programs

- Group Health Cooperative
  - 29% reduction in emergency room visits
- Community Care of NC
  - $135 million savings in Medicaid and SCHIP
  - $400 million savings in care for blind, aged, disabled
- Genesee Health Plan
  - 15% reduction inpatient hospitalizations
  - 50% reduction in emergency room visits
- Johns Hopkins
  - $1364 annual savings per Medicare patient

Challenges with PCMH

- No change to fundamental payment structure
- Additional payments often not adequate to support the transformations required
- Treats physician as scarce resource who only handles most complex cases, patient choice and relationship with provider a lower priority
- Difficult for smaller, independent practices to implement
Ambulatory ICU—Adventist

- Employer program with 7200 employees
- Started pilot program in 2009
  - Targeted 46 patients
  - Who seek care from 15+ providers
  - Taking 9+ prescriptions
- Goal
  - Move these employees out of high risk group
  - Save healthcare costs

Ambulatory ICU—Adventist

- PCP had access to personal health records
  - Patient diagnoses
  - Procedures
  - Hospital stays
  - Prescriptions
- Personal health nurse at third party administrator
  - Educated PCP on how to access online health records
  - Provided member progress reports to PCP
  - Reached out to patients to engage and provide coaching
- Patient access
  - Unlimited access to personal health nurse
  - One hour per month with PCP at no charge
Adventist results: after one year

• Most of the 46 members moved to “moderate” or “low” risk
• Change in utilization
  – 35% reduction for pilot’s participants
  – 0.9% increase for all other plan members
• Return on investment
  – Cost of $31,204
  – Savings of $87,365
  – ROI of 2.79
Challenges with Ambulatory ICU

• Only addresses limited population
• Some programs have difficulty attracting and enrolling members
• Difficult to scale
• Potentially fragments primary care
Worksite Clinics

- Employer controls access
- Employer has greater say in service offering
- Captures people at work, reduces time lost and other productivity costs due to medical
- Provides platform for changing health habits of the whole population
- Programs tailored to needs of that population
Challenges with Worksite Clinics

- Only available to employees while at work
- Family members usually don’t have access
- Employees might distrust clinic staff due to privacy concerns
- Further fragments care system by adding another locus of care to the community-based system
- Only an option for employers with very large numbers of employees concentrated in one location
Direct Primary Care—Qliance

- Launched in Seattle in 2007
- Replaces FFS with monthly fee
- Eliminates insurance billing overhead
- Open to all regardless of health status or age
- Reserves insurance for undesirable, costly, unpredictable health events
- Provides greater access than typical practices
Principles of DPC at Qliance

• **Service**—relentless focus on care of our customer (we work for the patient)

• **Relationship**—have to give patients and doctors/staff the time it takes to develop trusting, continuous, healing relationships

• **Stewardship**—manage healthcare resources from the primary care level

• **Systems Focus**—population-based care, meet the needs of patients and clients (employers) to help everyone meet their goals
Distinct Features of Qliance

- Doctors employed, salaried; encourages focus on holistic care
- Limited patient panel size (800-1200 people vs. 2500-5000)
- Unrestricted, 7 day/week access plus doctor on call after hours
- Longer visit times (30-60 minutes), multimodal encounters (phone visits, e-visits, video visits)
- No co-pays or other per-visit charges, everything is included
- Operate community-based, on-site and near-site clinics
- Proprietary IT platform tailored to care delivery model, supports data integration with carriers, purchasers, and other systems
# Qliance Services—Examples

<table>
<thead>
<tr>
<th>Included</th>
<th>Not Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Office, phone, electronic, and video visits</td>
<td>- Advanced radiology</td>
</tr>
<tr>
<td>- Acute care</td>
<td>- Specialist care</td>
</tr>
<tr>
<td>- Preventive care</td>
<td>- Emergency room</td>
</tr>
<tr>
<td>- Chronic disease management</td>
<td>- Ambulance</td>
</tr>
<tr>
<td>- X-rays</td>
<td>- Hospital care</td>
</tr>
<tr>
<td>- Basic generic dispensary medications</td>
<td>- Prescription drugs</td>
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<tr>
<td>- Basic lab work</td>
<td>- Maternity Care</td>
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<tr>
<td>- Care coordination with specialists, hospitals</td>
<td>- Nursing Home</td>
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<td></td>
<td>- Physical Therapy/Rehabilitation</td>
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</tbody>
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Qliance Target Market

- Started with individuals paying for themselves
- Now working with large groups
  - Self-funded plans
    - Primary Care
    - Onsite Primary and Urgent Care
  - Insurers
    - As primary care network option
    - As core primary care offering for DPC-specific plan
Qliance Patients Use Less Downstream Care

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Qliance # per year/1000*</th>
<th>Benchmark**</th>
<th>Difference</th>
<th>Savings PMPY***</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>73</td>
<td>158</td>
<td>-53%</td>
<td>$84</td>
</tr>
<tr>
<td>Hospitalizations (days)</td>
<td>155</td>
<td>184</td>
<td>-16%</td>
<td>$102</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>850</td>
<td>2000</td>
<td>-58%</td>
<td>$345</td>
</tr>
<tr>
<td>Advanced Radiology</td>
<td>273</td>
<td>800</td>
<td>-66%</td>
<td>$1054</td>
</tr>
<tr>
<td>Surgeries</td>
<td>28</td>
<td>124</td>
<td>-77%</td>
<td>$960</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>4411</td>
<td>1847</td>
<td>139%</td>
<td>($528)</td>
</tr>
<tr>
<td>Savings PMPY</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>$2017</td>
</tr>
</tbody>
</table>

* Based on best available internal data, may not capture all non-primary care claims.
** Based on regional benchmarks from Ingenix and other sources.
*** Based on average costs in WA State.

Source: Qliance Medical Group insured patients under 65, 2011 (n=3011)
Challenges with DPC Model

- **Unique offering**—needs to be integrated into overall health benefits plan
- **Insurers**—actuaries uneasy about ascribing greater value to primary care
- **HSAs**—current regulations unclear, IRS interprets DPC as “HMO-lite”, therefore not payable out of HSA funds and not allowable in front of HSA/HDHP
- **Limited availability** (although growing quickly)
Medical Homes & The Triple Aim

**Outcomes**
- Medical Homes more accountable for patients, better able to deliver consistent results

**Experience**
- Medical home models variable in delivery of better patient experience

**Cost**
- Growing evidence of cost-effectiveness of greater investment in primary care; could result in 5-30% savings in overall system cost
How Does the Medical Home Benefit Employers

- Improved employee health
- Improved recruiting & retention
- Increased productivity
- Better employee experience

Also:
- Combat rising healthcare costs
- Guarantee access to primary care, in some cases 24/7
- Focus on prevention and wellness
- Simplify benefits (reduce dependence on multiple fragmented service offerings)
Loss of Independent Primary Care: A Threat to Achieving the Triple Aim

- Episodes of care initiated by independent primary care providers substantially less expensive than those initiated by hospital-based primary care providers.
- Increasingly difficult for independent primary care providers to survive with low reimbursements and high cost of billing.
Purchaser Trends

Services
- Direct Purchasing
- On-site Clinics
- Telehealth

Plan Design
- Cost Exposure
- Higher Deductibles
- Incentives
The Opportunity for Employers

- Employer purchasing power driving innovation and rapid change
- Primary care as foundation of healthcare system
- Primary care provider (PCP) as steward of healthcare resources (purchasing agent for patients and payers)
- PCP as shared decision maker & true partner w/patients
- Employees as engaged patients & informed users of services
Considerations for Employers

- **HDHP + HSA**: Current regulations unclear on HSA’s and direct practice—Qliance is working on clarifying rules via IRS & Congress.

- **Plan design goals**: What are the problems you are solving for (i.e. increasing cost of care, overutilization, absenteeism, productivity, high chronic disease burden, lack of prevention, etc.)

- **Engagement**: incentives, plan design, marketing/communications to direct employees and dependents to the desired source of care (primary care) vs. undesirable care (advanced care).

- **Integration with existing plans**: Can your primary care solution exchange data and integrate into existing networks to simplify administration?

- **Alternative payment mechanisms**: monthly fee, hybrid monthly fee + utilization, performance guarantees, risk/gain share, modified fee for service, channeling of payments through carrier/administrator, etc.
Digging Deeper—More Questions to Ask Your Partners and Advisors

• Health Plan Partners—Look for ways to integrate innovative offerings into networks, share data, enhance value of other program elements
• Technology & Health Informatics—Look at what can innovative health IT do for you—clinical quality programs, provider reporting, patient and company/consultant portals, patient self-management, etc.
• Onsite & Near Site Clinics—Is onsite health right for you? Consider how this can be part of an overall solution and how non-traditional approaches can help you reach your goals.
• High Performing Networks—Ask your primary care providers to partner with high quality, high service, appropriately priced providers of secondary, tertiary, and ancillary services to expand impact on patients’ health and overall costs.
• Geographic Expansion—Have discussions with potential partners about expanding services to build in locations where your employees are.
THANK YOU!