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THE ADVANTAGES OF PCMH

Evaluating empowered primary care in US healthcare

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EXECUTIVE SUMMARY

The Institute of Medicine (IOM) defines[1] primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Primary care is often associated[2] with reduced costs, timely care, optimized utilization, reduced mortality, and higher patient satisfaction. Primary care is correlated with more equitable health outcomes and forms the foundation of effective, value-driven healthcare systems.

The Patient-Centered Medical Home (PCMH) model is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand[3]." The PCMH model's technology and data-driven performance metrics hold the key to meeting the aim of lower costs, increased quality, and increased patient satisfaction.

The whitepaper discusses trends in primary care services and explores innovative solutions to optimize care delivery and cost efficiency.
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HIGH COSTS AND UNNECESSARY UTILIZATION: PRESSING ISSUES

The US healthcare system must improve primary care to both meet cost and quality goals, and to continue to attract physicians. Implementing incentive and payment models that strengthen the patient's relationship with their primary care provider are necessary to meet the healthcare system's current and future cost reduction and appropriate utilization goals.

SPECIALTY-FOCUSED CARE AND EXCESSIVE AVOIDABLE VISITS

According to various estimates, only 5.8% to 7.7% of our healthcare spending goes[2] towards primary care. About 28% of male and 17% of female lack a PCP[5]. Almost half of 18-27 years have no PCP[6], denoting a trend towards visiting urgent care clinics among younger population.

ACCESS TO CARE

In some regions, low primary care utilization can indicate a shortage of providers rather than apathy amongst the population. One such example is that of rural areas. About 20% of the American population resides in rural areas[7] while only 9% percent of the physicians practice in rural regions.

In fact, physician shortage at both primary care has become a persistent issue. By 2030, the US could see[8] a shortage of up to 120,000 physicians, including a shortage of 14,800 to 49,300 primary care physicians.

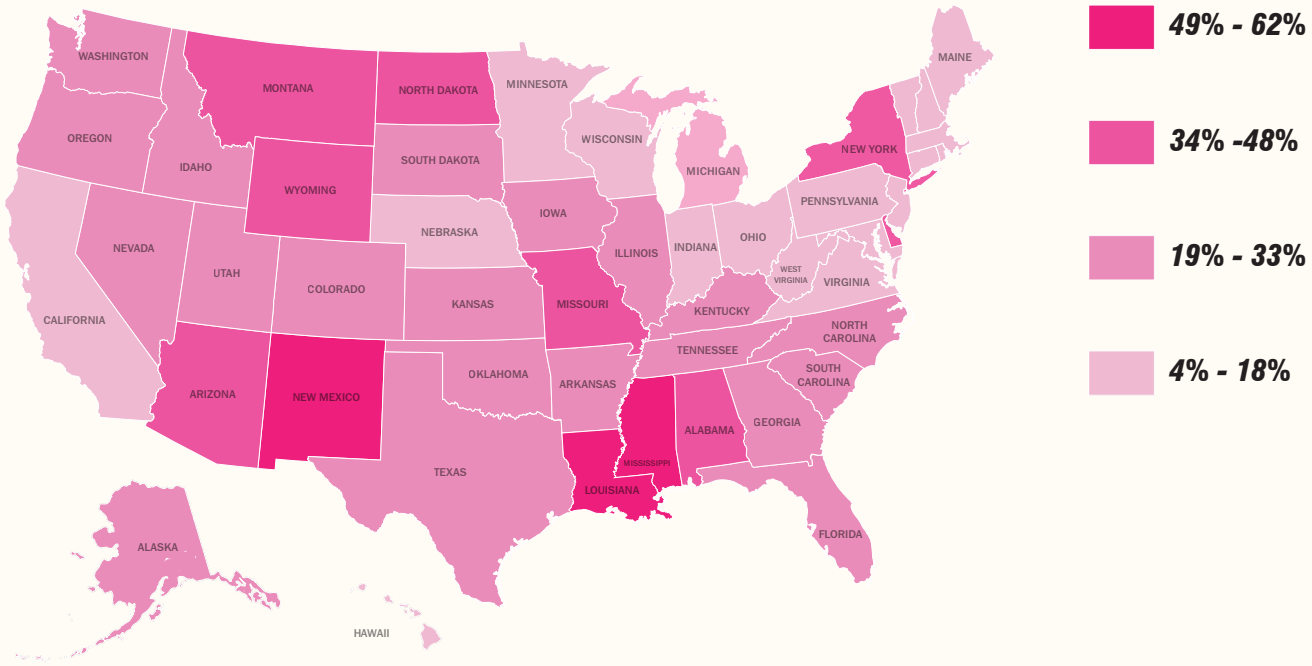

Fig 1: Percentage of Population Living[9] in a Designated Health Professional Shortage Area, 2011

LACK OF THE "CULTURE OF WELLNESS"

Disease-care rather than preventative care and wellness still predominates much of the country's healthcare system. Healthcare organizations often have patients attending their facilities only when they have some healthcare issues, and in some cases, patients even prefer directly going to EDs in extreme need rather than seeking out preventative care. Lack of interest in wellness-centric, primary care is already negatively impacting healthcare costs. From 2012 to 2016, visits[2] to primary care providers decreased by 18% while specialist spending increased 31%.

USING PCMH TO DRIVE HEALTHCARE TRANSFORMATION

Primary care focused healthcare delivery can act as a catalyst for reducing costs and improving quality of care. All populations– adult, senior, and pediatric– have benefited from implementing the PMCH model which was created by the American Academy of Pediatrics (AAP). In 2002, the AAP expanded its description of the model to include operational characteristics of care delivery that include "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care."

5 key attributes and functions can be associated[11] with PCMHs:

- Comprehensive care delivery to address patients' physical and mental health needs
- A patient-centric and whole-person approach to care delivery
- Coordinated care throughout the health care system
- Accessible care at all times
- A commitment to quality and patient safety

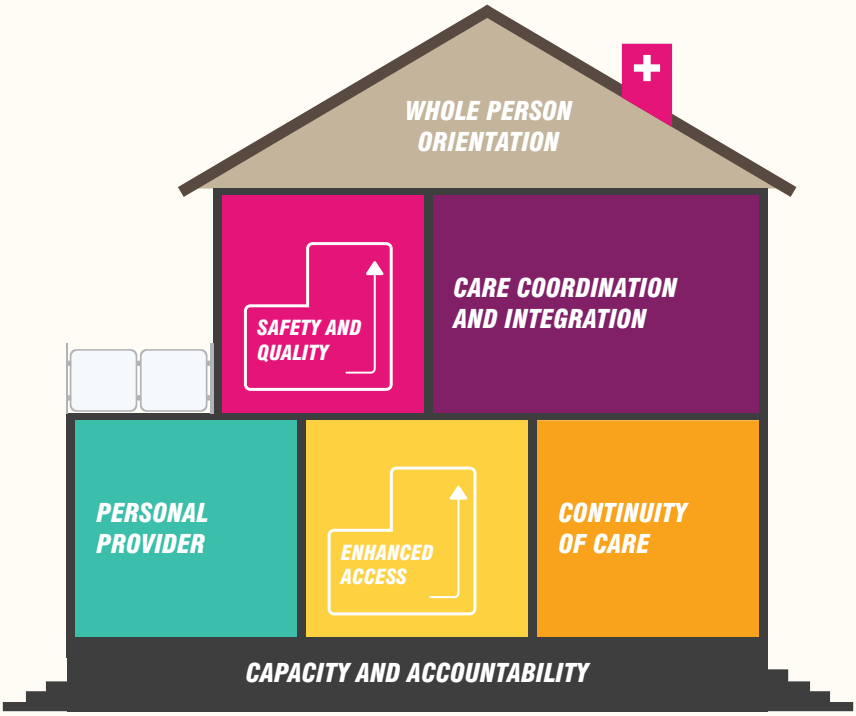

Fig 2: The attributes of a Patient-Centered Medical Home

THE PCMH APPROACH

Healthcare experts have emphasized building a care culture that is continuous and based on a strong and collaborative patient-provider relationship. The patient-provider relationship can exist for decades, and collaborative partnership between both parties coupled with regular, preventative checkups, timely interventions enhance the healthcare experience for both parties and decrease the need to specialist and hospital care.

Various local and national bodies provide PCMH recognition based on different criteria; however, the National Committee for Quality Assurance (NCQA) is the most prevalent accrediting body. NCQA-accredited organizations fulfill specific quality and cost benchmarks. Most PCMHs combine the traditional fee-for-service payment model with a hybrid care model that includes payments for coordinating care and incentives for quality improvement and various preventative activities.

BENEFITS OF THE PCMH CARE MODEL: HIGHER QUALITY OF CARE, LESSER UTILIZATION, AND LOWER COSTS

Most patients – regardless of their demographics – prefer an established and collaborative patient-provider relationship. With a patient-centric approach to care delivery, PCPs can ensure timely interventions, increased patient satisfaction, and improved satisfaction with their vocation.

Delivering high-quality primary care can reduce unnecessary ED utilization – a significant cost to the healthcare system. Preventative care visits along with extended hours and same day appointment availability limit the need for engaging with ED and urgent care providers resulting both in reduced costs and shorter wait times for patients experiencing genuine healthcare emergencies. A strong patient-provider relationship enables personalized care and a more ready acceptance of evidenced-based care guidelines by the patient.

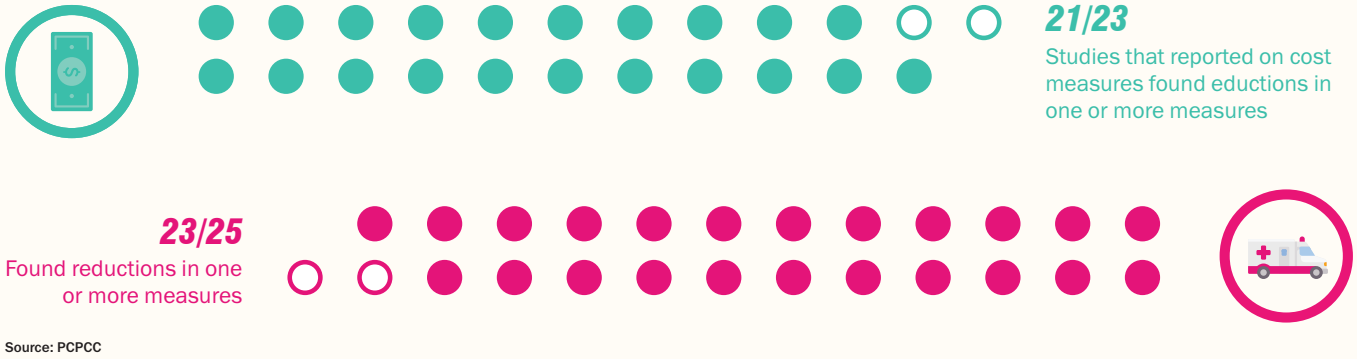

Fig 3: Benefits of leveraging the PCMH model of care, as reported by PCPCC

In a recent[12] PCPCC report , it was revealed that 91% percent of studies on the financial implications of adopting the PCMH resulted in reduced costs. Additionally, as many as 92% providers improved their performance on at least one measure.

PCMH AND VALUE-BASED CARE

The PCMH model will continue to play a prominent role as payers continue the migration from fee-for-service to value-based payments. Many Accountable Care Organizations (ACOs) implement the model to improve cost and utilization. In fact, ACOs with PCMH PCPs are more likely to generate[13] more savings. Such ACOs also report higher care quality in areas such as health promotion, health status, preventive service delivery, and chronic disease management scores.

At a broader level, ACOs and PCMH share core values, and successful ACOs have leveraged the key principles of the PCMH model to advance their care initiatives.

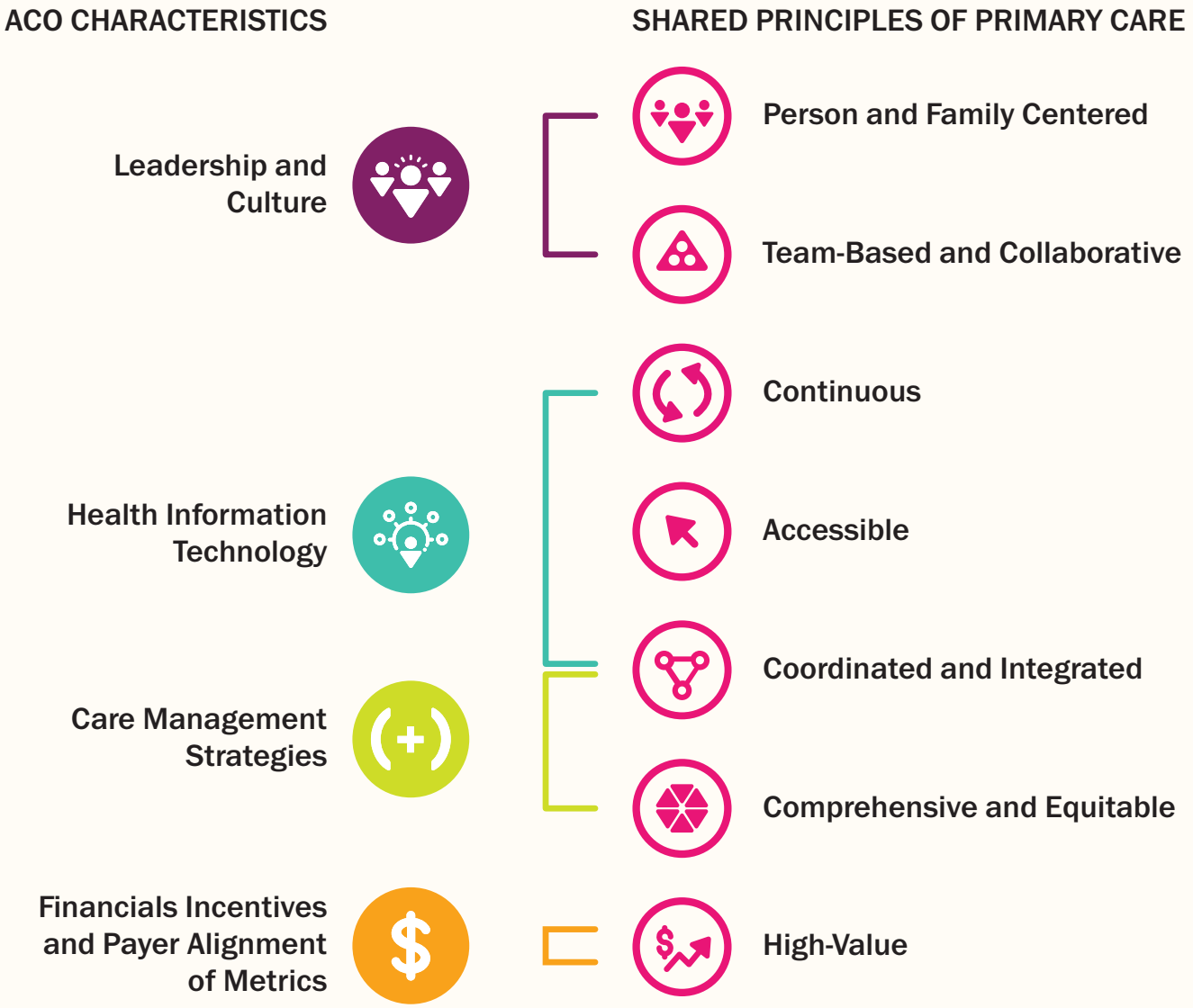

Fig 4: Characteristics of Successful ACOs Mapped to the PCMH Shared Principles

The traditional fee-for-service (FFS) model does not pay healthcare organizations[14] for implementing health IT initiatives, coordinating care, and team-based care. PCMH, however, is built by leveraging data to deliver comprehensive, evidence-based care. Each NCQA PCMH criteria correlates to value-based payment goals such as prompt medication reconciliation, disease management, risk stratification, and quality improvements.

Such care models are beneficial for all stakeholders. Integrating services across the entire care continuum and aligning with evolving payment models, enables practices to increase revenue, provide a better care experience, and keep workplace satisfaction.

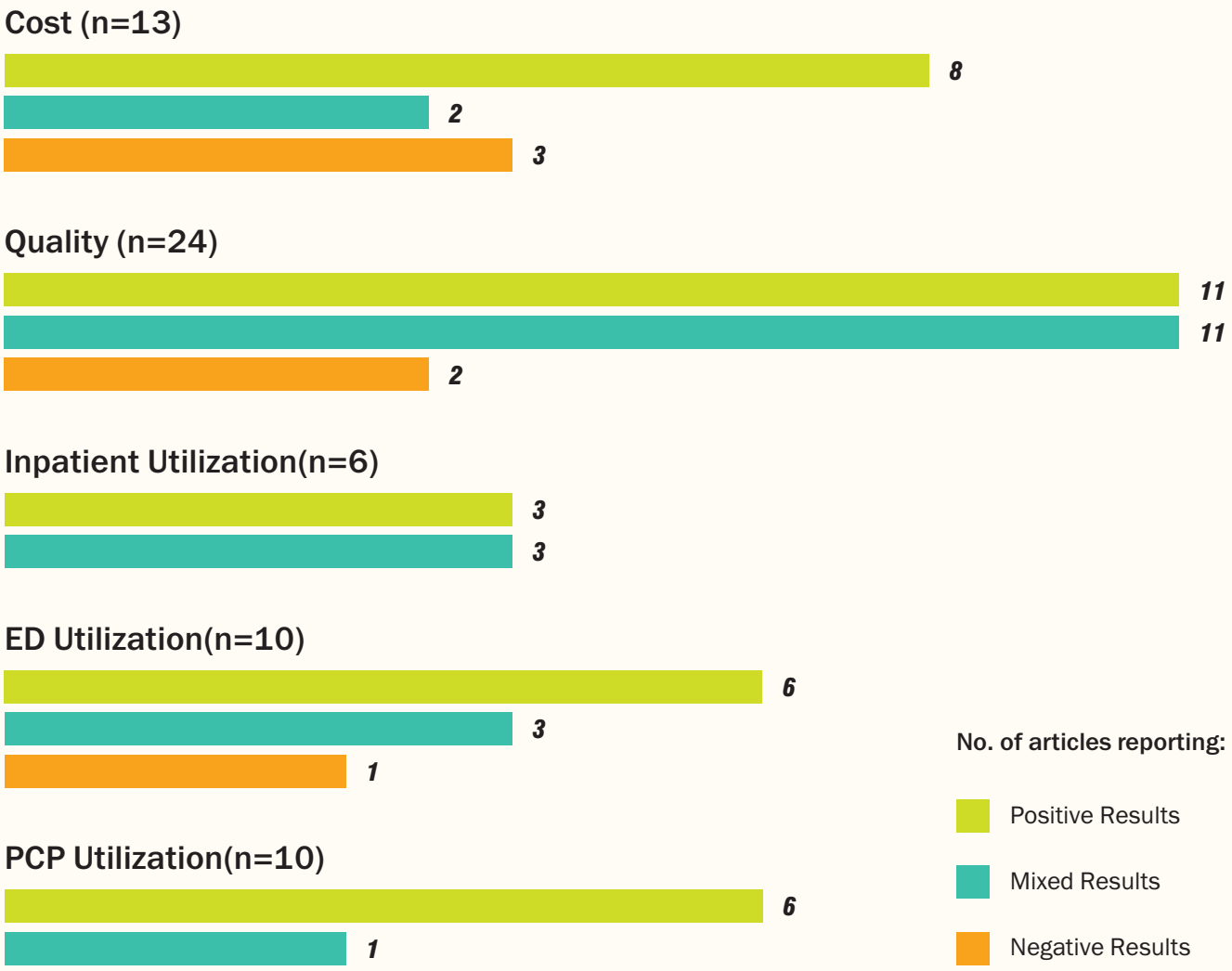

Fig 5: Impact of PCMH model on cost, quality, and utilization - Summary of Outcomes: Peer Reviewed Articles

In a survey published by PCPCC and the Robert Graham Center[15], positive impacts from implementing the PCMH model of care were found. The same survey also established that the longer a practice the PCMH accredited, the greater the impact is on the cost savings. According to another analysis[16] completed in 2013, significant difference between PCMH and non-PCMH organizations was found, and the divergent trend only increases over time.

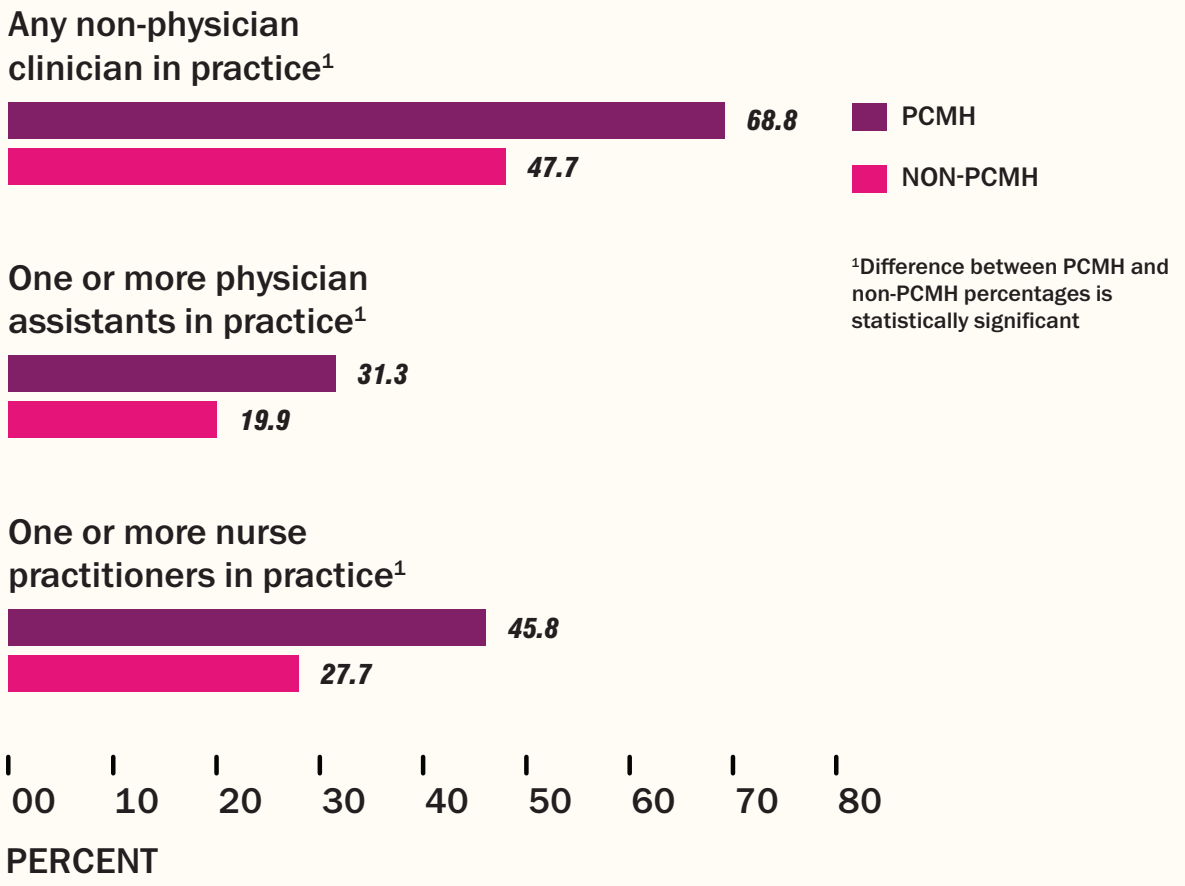

Fig 6: Characteristics of Primary Care Physicians in Patient-centered Medical Home Practices: United States, 2013[16]

A DATA ACTIVATION PLATFORM EMPOWERS NETWORK ANALYTICS

Innovaccer's Data Activation Platform is purpose-built for improving healthcare technology by enabling genuine connectivity across multiple data sets including the social determinants, pharmacy, EMR, and claims data. With its 200+ automatic connectors to widely used healthcare data systems and applications, the platform enables rapid data ingestion and integration for high-performance data analytics. The data activation platform pieces together disparate data sources into a unique, longitudinal Patient-360 records which are exchanged via industry-governed standards. The platform ensures that providers don't make decisions based on an incomplete data, but instead reach beyond their EHRs to access the right sets of data to power smart clinical interventions and analyze cost trends.

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Industry's Most Powerful Analytics Tool for
Population Health Management

innote

Point-of-care Assistant for
Physician Engagement

incare

Smart, AI-assisted
Care Management Solution

inconnect

One-stop
Patient Engagement Solution

To provide a holistic environment, the following solutions are built on Innovaccer's Data Activation Platform:

incare

A smart, AI-assisted care management solution, with PCMH level care delivery, built into the workflow. InCare streamlines the care management process enabling systems to scale care management programs at lower costs, and with higher quality.

ingraph

InGraph is the industry's most intuitive healthcare analytics offering for population management with over 800+ measures to track network performance and outcomes, customizable measures and dashboards accessible across the network, and automated quality measures reporting.

innote

A smart, lightweight digital assistant for physicians that provides population health insights derived from multiple data sources at the point of care. InNote, insights such as care gaps, dropped codes, process measures, and referral information can be shared with the clinician without leaving their EHRs.

inconnect

An automated analytics-driven patient engagement solution to scale patient outreach workflows and bring patients closer to the care team.

CONCLUSION

Improving care quality is challenging. However, the industry is in an exciting era of innovation in primary care delivery. The PCMH model is maturing over time and leading to waves of advancements throughout the healthcare system. Increasingly, organizations are empowering preventive primary care to cut costs and maximize incentive derived revenue. However, much work still needs to happen as the CDC has noted that americans still use preventive health services “at about half the recommended rate.”

Various organizations are now leveraging non-clinical factors to reduce their populations’ vulnerability to potential diseases by increasing patient awareness and involving them at each care event. Organizations are now initiating strategies to address the most pressing issues of patients. For instance, regular check-ups, preventative exams and tests, and timely vaccination are recommended[18] as preventive care measures. With a data-driven approach, PCMHs not only work to address such measures but are firmly leading the push towards a preventative focused, primary care driven delivery system.

By fostering a strong patient-provider relationship, utilizing advanced technologies to deliver personalized care, and adding accountability into the overall care landscape, PCMHs stand at the forefront of value-driven in care that goes beyond disease-care to healthcare.

ABOUT INNOVACCER

Innovaccer Inc. is a leading healthcare data activation company making a powerful and enduring difference in the way care is delivered. Innovaccer's aim is to make full use of all the data our industry has worked so hard to collect by righting the wrongs, doing away with long-standing problems and replacing them with ideal solutions. The Gartner and KLAS-recognized products have been deployed all over the US across more than 500 locations, letting over 10,000 providers transform care delivery and work as one. The data activation platform has been delivering value to several institutions, governmental organizations, and several corporate enterprises such as Mercy ACO, StratiFi Health, UniNet Healthcare Network, Catalyst Health Network, Hartford Healthcare, and Osler Health Network. Innovaccer is based in San Francisco and has offices all over the United States and Asia.

For more updates, visit www.innovaccer.com.

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