



# The Transformation of Health Care in North Dakota

North Dakota Legislature  
Health Care Reform Review Committee  
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# Overview

- The New Reality
- Principles of the Patient Centered Medical Home
- History of MediQHome Quality Program at Blue Cross Blue Shield of North Dakota
- Current status and results of MediQHome
- Future of medical homes in North Dakota

# The New Reality

- The Affordable Care Act is the largest transformation of healthcare in 40 years
- By 2022, first time coverage for an estimated 27 million uninsured via Exchanges (15 million) and Medicaid (12 Million) <sup>1</sup>
- Relationships between providers, payers, and consumers will irrevocably change through Essential Health Benefits (EHB) design, integrated care, shared savings, and risks tied to evidence based outcomes driven care

<sup>1</sup> Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes, and Innovations: Workshop Summary Pierre L. Young, LeighAnne Olsen, and J. Michael McGinnis; (National Academy of Sciences); Institute of Medicine's report.

## Why the urgency?

- U.S. has highest per capita health care spending of any industrialized nation—50% greater than second highest and twice the average for Europe <sup>2</sup>
- Our costs outpace price and spending growth rates for rest of economy by a considerable margin <sup>3</sup>
- Significant part of total spend from over, under, or misuse of treatments relative to evidence of their effectiveness
- Of 2.8 trillion spent in 2012, 75% on chronic illnesses.
- 1% of population uses 20% of resources. 5% use 50%

2-3 Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes, and Innovations: Workshop Summary Pierre L. Young, LeighAnne Olsen, and J. Michael McGinnis; (National Academy of Sciences); Institute of Medicine's report.

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4

Compelling data show much of spend does little to improve health, and sometimes leads to poorer health.

# The Numbers



- 2.5 trillion spent on healthcare in 2009
- Per Institute of Medicine, 765 billion in waste <sup>4</sup> (30% of total spend) from:
  - Unnecessary services (210B)
  - Excessive Administrative costs (190B)
  - Inefficiently Delivered Services (130B)
  - Prices too high (105B)
  - Fraud (75B)
  - Missed Prevention (55B)

<sup>4</sup> The Healthcare Imperative: Lowering Costs and Improving Outcomes; Workshop Series Summary, Institute of Medicine, National Academy of Sciences, Washington, D.C.;

# Challenges to the System

- **Outcomes** fall short of expectations
- **Fragmented** decision points
- **Inconsistent** principles and political distortions
- Scientific **uncertainty**
- Perverse economic **incentives**

## Challenges cont.

- **Opacity** as to cost, quality, and outcomes
- **Changes** in the population's health status
- Lack of patient **engagement** in decisions
- **Under-investment** in population health

# Why Medical Homes

- Insufficient primary care physicians (PCP) and physician extenders to meet current access demands
- The Affordable Care Act (ACA) places additional demands on PCP access
- Current Primary Care Business model cannot achieve desired outcomes
  - Average panel size for many practices 2300
  - A primary care physician with a panel of 2500 average patients will spend 7.4 hours per day doing recommended *preventive care* [Yarnall et al. Am J Public Health 2003;93:635]
  - A primary care physician with a panel of 2500 average patients will spend 10.6 hours per day doing recommended *chronic care* [Ostbye et al. Annals of Fam Med 2005;3:209]

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# Why Medical Homes

- To extend primary care access
- To organize care to ensure accessible, patient-centered, coordinated care
- To align financial incentives to enhance value and achieve savings
- To meet and raise benchmarks for high-quality, efficient care

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9

# Origins of the Medical Home

- AAP: pediatric practices for children with special needs (1967) - medical home
- AAFP: Future of Family Medicine report (2003) - medical home
- ACP: "advanced medical home" (2006)
- IBM, with employees all over the world, concluded that they could buy high quality care at reasonable cost in every country except the US
- Analysis: US needs strong primary care
- IBM brought together AAFP, ACP, AAP, and American Osteopathic Association, resulting in Joint Principles of the Patient- Centered Medical Home (2007)

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10

## PCMH defined - Transforming the Process

- Medical Home—a model of primary care that redistributes existing physician-only work to a shared responsibility amongst all clinic staff (physician extenders, nurses, etc.)
- Process change allows for patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.
- The medical home is not a final destination. It is a framework for achieving primary care excellence so that the right care is received in the right place, at the right time.

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11

# The Components of Medical Homes

- Team Based Approach to Care
  - No longer dependent on face to face visits for care and revenue
  - All practice staff (MA and RN have responsibility for care management)
- Care Management
  - Disease registries are used to ensure timely chronic care and preventative services
  - Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations

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12

## The Components cont.

- Care Coordination
  - Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services , imaging, all ancillary services, etc.
- Enabled Technology
  - Using information technology to improve patient care (e.g., electronic health records with registries, reminders, e-prescribing, and clinical decision support)
  - Reporting quality and patient experience measures

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## What does a mature medical home look like?

- Physician reliance on the one-on-one, face-to-face visit is obsolete
- Physicians are clinical leaders of the team, see 8-10 patients per day, consult with team members, interact with patients by phone, e-mail, video conf, etc.
- Mature PCMH:
  - Physician time = 1/3 face-to-face visits and video conf, 1/3 phone visits and e-mail visits, and 1/3 supporting care team

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- Many routine acute, chronic and preventive care needs can be handled by other team members– NPs, PAs, RNs, MAs, etc.
- Physicians should use their face to face visits for patients requiring their diagnostic and management expertise
- Patients may be cared for via multiple encounter modes – phone visits, e-mail visits, distance encounters, visits to non-physician team members, group visits

# History of MediQHome

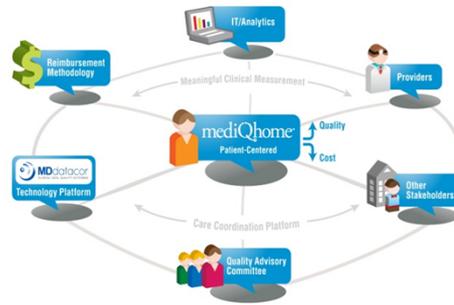
- Pilot program in 2005
- Expansion of pilot in 2007
- Statewide launch of MediQHome Quality Program in 2009

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15

# History of MediQHome

- Increased Quality
- Decreased Costs



*“The right care, for the right person,  
at the right time, for the right cost”*

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16

In order to provide effective health care and contain costs, need to change the way we deliver health care.

Goals of MediQHome:

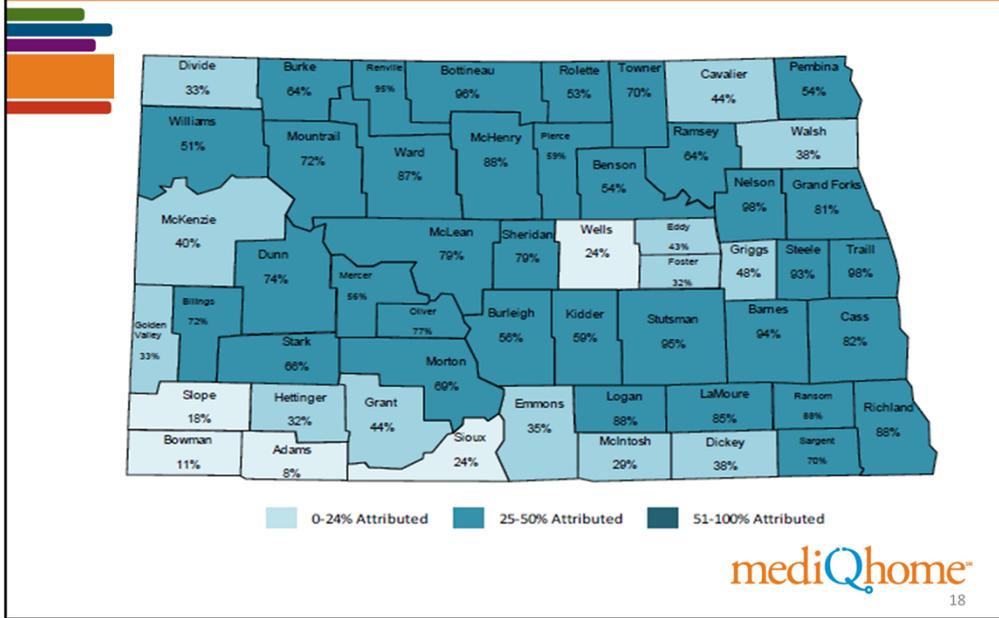
## Current Suites in MediQHome

- Asthma
- Attention Deficit  
Hyperactivity Disorder
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes
- Hypertension
- Breast Cancer Screening
- Colon Cancer Screening
- Cervical Cancer  
Screening
- Tobacco Use Assessment
- Immunizations
- Vitals Suite

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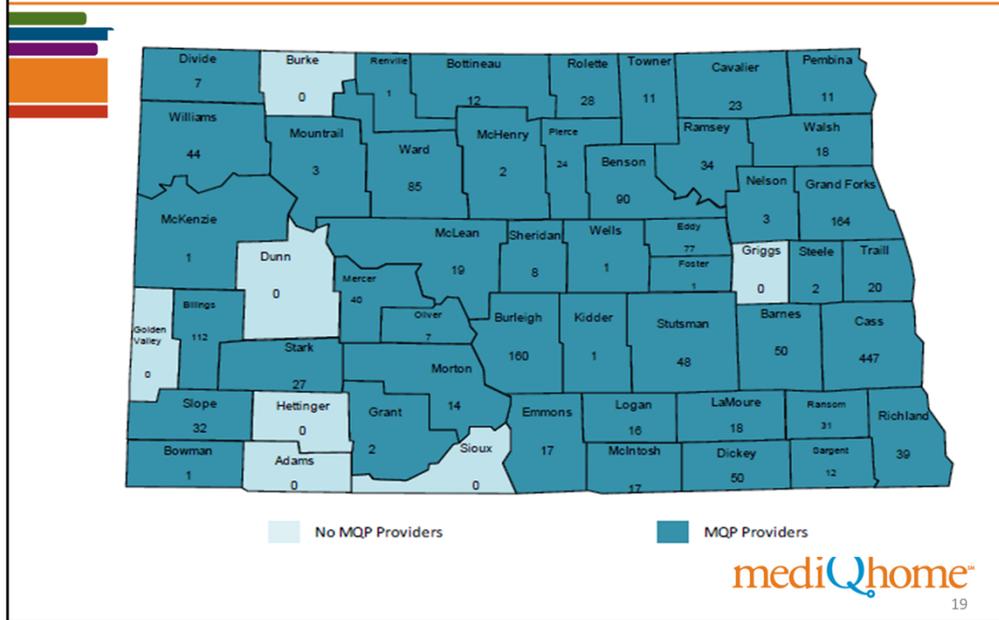
17

# Member Participation



Overall, 80% of BCBSND members residing in ND are in the MediQHome program.

# Provider Participation

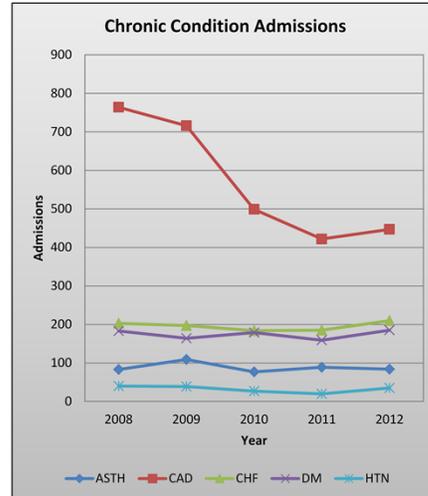


Overall, 75% of primary care physicians in ND are participating in the MediQHome program.

# Inpatient Admissions



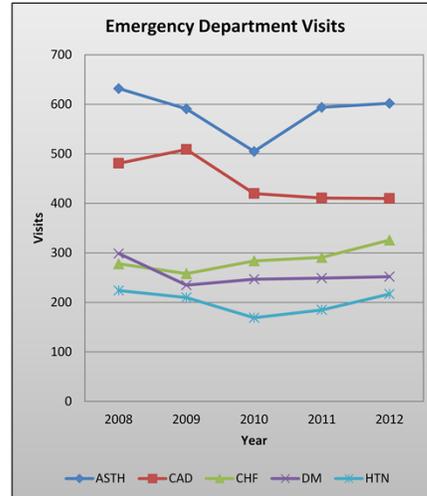
- Biggest impact was Coronary Artery Disease (CAD)
  - Reduced 200 admissions from 2009 to 2010
  - Avg cost/admission: \$35,000
  - Estimated savings of \$7.2 million



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# Emergency Department Visits

- Overall trend is stable
- Again, CAD had largest decrease
  - 100 less visits from 2009 to 2010

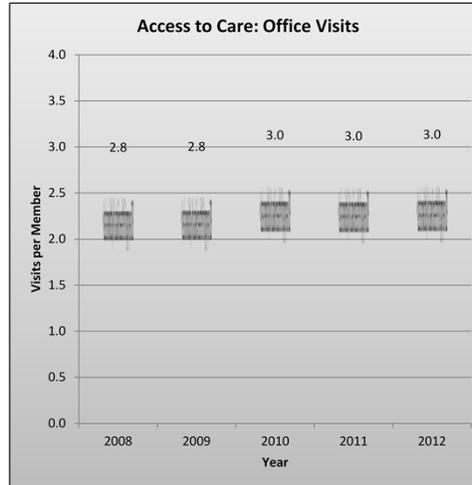


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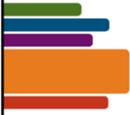
21

# Access to Care

- Access has remained stable, with a sustained increase after the first program year in 2009



## Key Clinical Metrics



Condition	Measure	2010 Compliance	2013 Q2 Compliance
Coronary Artery Disease	Optimal Vascular	15%	31%
Diabetes	Optimal Diabetes	20%	21%
Hypertension	Blood Pressure <140/90	66%	75%

Optimal Vascular: BP outcome, LDL outcome, Aspirin Use, Tobacco Free

Optimal Diabetes: BP outcome, LDL outcome, A1c outcome, Tobacco Free

## Reimbursement Methodologies

- Evolved each year of the program
- Currently, for each BCBSND member with a chronic disease condition, the provider receives a semi-annual Care Management Fee (CMF)
- CMF is first based on whether or not the member has a single chronic condition or multiple chronic conditions

# Reimbursement Methodologies

- The CMF is “quality tiered” based on the clinical outcomes of 3 suites:
  - Optimal Diabetes
  - Optimal Vascular
  - Optimal Hypertension)
- This quality tier has the potential to increase the Providers’ CMF up or down from their baseline

## Current Barriers

- “Is the data correct?”
- “It’s not enough reimbursement!”
- “Where’s the patient?”
- “The tool is not good enough!”
- Physician compensation

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MediQHome was intended to be the vehicle to achieve the principles of a patient centered medical home. Instead it’s been about the tool, implementing and training on the use of the tool and getting and keeping the data accurate

Providers willing say they only engage with the measures that are incentivized – amount of incentive not enough to drive massive behavior change

Lack of patient engagement and knowledge of the program due to lack of aligned incentives between the provider and the member/patient.

Requires access and sign-in to two disparate systems (MDI and EMR) to utilize tool. Need a single sign-in or integration between the platforms.

## Current Successes

- Increased awareness of PCMH in the state
- Beginnings of successful implementation of alternative reimbursement to providers
- Interactive disease registry for 6 common chronic diseases
- Focus on clinical quality outcomes
- Set the stage for Accountable Care Organizations

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28

## Future State

- MediQHome Version 2.0
  - Build on quality outcomes reporting
  - Address the dissatisfaction
  - Continue to promote all the components of PCMH
    - 24/7 access, e-medicine, etc.
  - Allow flexibility for innovation to occur in the practices that are more “PCMH-ready”

Thank You



Questions?

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