



Leadership and Innovation
in Primary Care of the
Elderly and the Chronically Ill

A Solution for Cost-Effective, Quality Primary Care



Urban Medical: Background

- Primary care practice founded in 1977, serving all adults and specializing in the elderly, chronically ill, and complex patients
- Team based care provided across settings: office, home, nursing home, and hospital
- Track record of designing and incubating innovations in primary care for target high risk populations

Track Record of Innovation

- Primary care in nursing homes
 - *Model replicated in nursing home care nationally (Evercare)*
- Capitated primary care programs for elderly and multiply chronically ill
 - *Model replicated statewide in Massachusetts (Commonwealth Care Alliance)*
- Multiple current initiatives to improve quality and redesign primary care
 - *Grant-funded research to evaluate House Calls program*

The Model: Proactive Primary Care with Care Coordination

- NP/MD Teams – horizontal rather than vertical relationship. (MD no longer “the boss”)
- Team supported by Care Coordinator and (for House Calls) a Social Worker
- Care provided in office, home, senior housing, assisted living, nursing homes and hospital
- Trusted referral relationships with specialists and inpatient involvement

Best Practices

- ❑ Proactive, frequent patient visits
- ❑ Focus of care is the patient and family or caregiver: build them as a team
- ❑ Teaching patients and caregivers to watch for ominous symptoms
- ❑ Easy availability of clinicians 24/7 as alternative to ER
- ❑ Giving patients thoughtful control of hospitalization and end of life decisions – and making this a recurrent theme of care

Best Practices - continued

- ❑ Partnership with housing providers to support aging in place
- ❑ Care coordination by non-clinical team member to make sure that tests, prescriptions and referrals actually happen and to provide links to social services
- ❑ Transition coaching of patients and families after discharge from hospital and rehab
- ❑ Linking or integrating mental health care

Results: Reduction in Total PMPM

Plan/Population	Results
Commonwealth Care Alliance (SCO)/Nursing home certifiable at home (June 2006-May 2007)	Medical expense ratio: 59.5%
Evercare/Long term care (2000-2007)	Medical expense ratio: 64%
Secure Horizons/Medicare beneficiaries (1995-2000)	68% of AAPCC

Commonwealth Care Alliance Cohort

- Dual eligible, nursing home certifiable patients cared for at home
- Average of 90 patients per month with mean age of 77
- Average risk score: 2.40
- 40% with congestive heart failure
- Results (Year ending 5/31/2007):
 - NO hospitalizations for CHF
 - 20% lower risk-adjusted ER spending

Why does CCA/Urban Medical model work so well?

- ❑ Reliance by CCA on primary care providers to make decisions and coordinate care
- ❑ Flexibility and creativity in how Medicare and Medicaid \$\$ spent
- ❑ Risk adjusted primary care capitation that covers the cost of robust care model
- ❑ Quality measurement and timely feedback to primary care practice
- ❑ Financial incentives for quality and cost efficiency

Cost of Urban Medical Model

- Primary care with care coordination in this model is 10 to 12% of total PMPM (versus 5% on average) but the result is as low as 60% of risk-adjusted average total PMPM spend.
- *Average* primary care costs per patient per month vary widely based on risk:
 - range from \$40 for office patients (who are seen on average of 2 times/year)
 - \$150 on average for all House Calls patients
 - \$370 for the most frail and complex.

Implications

- A redesigned, enhanced primary care system for enrollees with the highest predicted cost can lower costs by ~ 20% of premium
- For this to occur, what is needed is:
 - A risk adjusted monthly primary care payment to allow an intervention tailored to the patients level of need
 - Incentives tied robustly to both quality and low total PMPM spending via shared savings from payers via global capitation
- Result: Primary care teams can energetically focus their creativity on innovations to prevent costly health crises

Replication: what will it take?

- ❑ Robust and well designed payment for primary care is absolutely necessary but not sufficient
- ❑ Implementing IT and infrastructure for chronic disease management is a major journey
- ❑ Fundamental to this is a culture and vision for teamwork, innovation and patient-centered quality

In conclusion,

“From a patient’s perspective, a medical home is not simply a combination of disease registries, reminder systems, and performance measurement. A medical home is a familiar place, with familiar people, that delivers high-quality, well-organized care that is accessible in time of need.”

Rittenhouse, et al. Health Affairs, Sept/Oct 2008