Volume 9, Number 1 January, 2017

Medical Home NEWS

Response to Depression Treatment in the Aging Brain Care Medical Home Model

By Michael LaMantia, Anthony J. Perkins, Sujuan Gao, Mary Austrom, Cathy Alder, Dustin D. French, Debra Litzelman, Ann Cottingham and Malaz A Boustanil

Depression among older adults is common, a major cause of disability, and is associated with increased mortality. The rate of major depression in community-dwelling older adults is ~2%, although the rates are higher among hospitalized individuals. Minor depression is more common still with rates varying from 9.8% among seniors dwelling in the community to 14%–25% among older adults who are hospitalized.

Depression is associated with costs that accrue to society, families, and individuals by a variety of mechanisms, including lost productivity, time away from work, costs for the treatment of depression in patients, and increased costs for treating comorbid conditions in patients. Due to its prevalence, burden, and associated costs, depression has become a major target condition for health programs that wish to improve the care of older adults.

(continued on page 3)

In This Issue

What Are the Long-Term Clinical And Economic Benefits For A Medical Home "On Steroids"?

By Jerry Reeves, M.D. and Brian Kapp

A "medical homes on steroids" refers to patient-centered medical homes serving populations enrolled in value-based benefit plans with strong incentives for participants and contracted physicians to develop and implement shared care plans.

Interventions

Beginning July 2011 a multi-employer health benefits trust offered union members and dependents ("participants") two health benefit plans. Participants could enroll either into a preferred provider organization (PPO) health plan with higher member cost sharing or a medical home benefit plan with lower member cost sharing. Adult participants enrolling in the medical home benefit plan were required to designate a medical home physician as their source for ongoing primary care from a subnetwork of approved medical home providers. They were also required to comply with personal care plans developed between them and their designated medical home physician. Care plans included a recommended schedule of visits and preventive and diagnostic services, medication refills, and required patient notifications of medical services not ordered by the medical home physician. Participants who notified their medical home physician could continue to see specialists of their choice. To retain the preferred cost sharing afforded by the medical home benefit plan adult participants were required to follow their care plan throughout the plan year.

Physician contracts specified customer service standards, quality of care guidelines and total care cost targets necessary to quality for semiannual performance bonuses. Medical homes offered rapid answers and return calls from phone lines dedicated exclusively to the medical home benefit plan participants, same day appointments for acute care needs, sixty-minute turnaround time from entry to exit for scheduled appointments, and customer friendly communications.

(continued on page 5)

A Medical Home "On Steroids"…*continued from page 1*

Personal health coaches were available to help patients referred to the health management program to achieve goals the patients established. Participating medical home physicians were offered assistance with timely entry of patient encounter and clinical data into the online registry containing medical and pharmacy claims data, preventive and diagnostic test results, health risk assessments, and health coach entries.

The plan sponsor contracted with a subnetwork of medical home physicians, offering them substantial performance incentives including higher global payments and simplified billing for office based care and eligibility for 50% bonuses distributed each six months. To qualify for the outcomes-based bonus payment, achieving all three of the following performance benchmarks was required: a.) validation of total claim costs below actuarial expectations for the patient population they served; b.) achievement of quality of care benchmarks established by the program; and c.) patient satisfaction scores exceeding 85% on returned patient surveys sent after each office visit. Participating physicians received population health management reports at least monthly listing their patients needing particular clinical services and displaying patients with disproportionately high costs and utilization.

Evaluation Process

Cost

A data warehouse was used to track and report plan eligibility as well as total medical and pharmacy cost. Baseline costs during the 12-month period preceding the intervention's effective date were calculated on a per participant per month basis for participants in the medical home benefit plan. Baseline costs were then used to develop actuarially expected per participant per month total medical and pharmacy cost projections in accordance with industry standards. These were reviewed and approved by several health benefits consulting firms. Total medical and pharmacy costs per continuously enrolled participant per month for the participants in the medical home benefit plan ("actual costs") were then compared to the actuarially expected cost projections semiannually to assess the financial performance of the medical home benefit plan strategy.

Quality

Quality of care measures were tracked for preventive services and chronic condition management. For participants diagnosed with a prevalent controllable chronic condition by July 1 of each annual review period, measures of completion and control of chronic condition tests were annually compared to benchmarks and the physicians' results from prior periods, then tabulated to assess performance.

Satisfaction

Patient responses on returned patient satisfaction surveys regarding overall patient satisfaction, quick answers to phone requests, same day appointment availability for acute conditions, and less than 60-minute office visit turnaround from entry to exit were tabulated semiannually to assess performance.

Results

Cost:

2013

For Plan Year 2013, participant per month total medical and pharmacy claim costs were 10 percent lower compared to the costs in the baseline year (2011) and 26 percent lower compared to the actuarially expected costs for that same period (Plan Year 2013). The net savings to the plan sponsor on a population of 1,609 participants was $1,476,418.

2014

For Plan Year 2014, participant per month total medical and pharmacy claim costs were 20 percent lower compared to these costs in the baseline year and 39 percent lower compared to the actuarially expected costs for that same period (Plan Year 2014). The net savings to the plan sponsor on a population of 1,784 participants was $2,858,467.

2015

For Plan Year 2015, per participant per month total medical and pharmacy claim costs were 14 percent higher compared to the costs in the baseline year (2011) and 19 percent lower compared to the actuarially expected costs for that same period (Plan Year 2015). The net savings to the plan sponsor on a population of 1,784 participants was $ 1,227,619.

2016

While Plan Year 2016 analysis is still in progress, participant per month total medical and pharmacy claim costs through June 2016 were 5 percent higher compared to the costs in the baseline year (2011) and 29% lower compared to the actuarially expected costs for that rolling 12-month period (July 2015 – June 2016).

Sources of savings are displayed in Table 5 on the following page. There were significant reductions in hospital cost and use, discretionary outpatient elective surgeries, emergency department visits, and high cost imaging services. Number of filled prescriptions and proportional use of generic drugs increased.

(continued on page 6)

A Medical Home "On Steroids"

...continued from page 6

Table 5 – Key Cost & Utilization Metrics

Participants Eligible 1-12 Mos.	2013 Results Increase/ Decrease % from Baseline	2014 Results Increase/ Decrease % from Baseline	2015 Results Increase/ Decrease % from Baseline	R12 Results Increase/ Decrease % from Baseline
Inpatient PPPM	+5%	-32%	+32%	+12%
Admissions per 1000	-19%	-24%	-21%	-28%
Bed Days per 1000	-27%	-32%	-13%	-9%
Outpatient PPPM	-17%	-19%	-5%	-12%
Procedures per 1000	-26%	-27%	-33%	-30%
Imaging per 1000	-35%	-48%	-46%	-48%
ER visits per 1000	-24%	-51%	-73%	-72%
RX PPPM	-6%	-8%	+49%	+51%
RX Generic %	+21%	23%	+20%	+19%

Source of Cost Savings:

There were significant reductions in hospital cost and use, specialist utilization, discretionary outpatient elective surgeries, emergency department visits, and high cost imaging services for each plan year reviewed compared to rates the baseline year. Number of filled prescriptions and proportional use of generic drugs increased.

Quality:

The percentage of patients obtaining recommended preventive and chronic condition management quality measures exceeded 80 percent for each plan year. Moreover, the frequency that chronic condition quality measure results were brought into the control range steadily increased during the study period, indicating improved levels of disease control.

Satisfaction:

The percentage of patients satisfied with each customer service benchmark on patient satisfaction surveys sent to participants following each medical home office visit remained well above the target of 85% for each plan year of the study period. Enrollment steadily increased each year of the 5 year study period.

Among the 40 volunteer participants who participated in face to face customer interviews, more than 92 percent rated as "important" continuity care by a medical home physician offering the service standards of this medical home benefit plan. More than 88 percent rated as "important" keeping out of pocket costs like deductibles, co-pays and coinsurance at, or close to, the levels currently offered.

Physician satisfaction remained high during the five years of the study. All participating primary care physicians earned their full performance bonuses for 149 of 150 individual semiannual bonus calculation periods.

Lessons Learned

- Medical home benefit plans that align strong rewards and consequences for participants and continuity care primary care physicians to develop and implement shared care plans and evidence based care guidelines can result in significant long term cost savings, improved health outcomes, and high satisfaction.
- Frequent clear communication of expectations with assistance for accomplishing goals of participants are associated with steady improvements in results.
- Sustained engagement of patients in shared care plans is as important as physician engagement in improving results.

1. Reeves J, and Kapp B. "Medical Homes on Steroids- Aligning Doctor and Patient Incentives Drives Superior Outcomes." *Medical Home News*. 2011; 3:1-7.
2. Reeves J, and Kapp B. "Improved Health, Cost, and Satisfaction with a Health Home Benefit Plan for Self-Insured Employers and Small Physician Practices." *J Ambul Care Manage*. 2013; 36: 108-120.

Jerry Reeves, M.D. and Brian Kapp are the Medical Director and Chief Executive Officer of wellPORTAL Inc. in Las Vegas.