Patient-Centered Medical Homes

Better Care, Better Value

By **Debbie Reczynski** and **Katie Carow**

Innovative healthcare systems aren't waiting for national action on health reform to address issues of quality, costs, and access in their communities. Many have been developing promising new solutions for years. Geisinger Health System, Danville, PA, is one system that has caught the attention of policymakers—and its medical home model offers lessons for any healthcare executive interested in delivering a better care experience while controlling costs.

Geisinger introduced its patient-centered medical home model, called the "personal health navigator," in 2006, as one way of meeting the system's lofty goal of becoming "a high-value delivery system." "We defined value in line with the Institute for Healthcare Improvement's 'Triple Aim' goals for healthcare transformation and laid out three objectives: improving the patient experience, improving quality of care and outcomes, and improving the cost trend," says **Richard M. Gilfillan, MD,** Consultant to Geisinger Health System and former chief executive officer of Geisinger Health Plan.

Those objectives guided the development of the medical home model. For instance, to improve quality and outcomes, Geisinger looked at how primary care practices and the health plan could work together to better coordinate and manage care. And it helped that Geisinger physicians were already in the process of transforming their practices to be more patient-centric.

Hardwiring Quality

The electronic health record (EHR) already in use at Geisinger's 35 primary care practice sites emerged as a key tool. Practices had started using EHRs to deliver more evidence-based preventive care and chronic disease management in 2005. With the medical home approach, capabilities were added to enable the EHR to generate time-of-service reminders for nursing staff to help patients manage chronic conditions. For example, in the case of a patient with diabetes, the system automatically issues a prompt when it is time for a blood sugar check, an eye exam, or a foot exam. "When a patient comes in for care, the EHR pops up on the nurse's Electronic Rooming tool, listing all of the things the nurse needs to do on that visit," explains Gilfillan.

"Having a system like this for tracking and monitoring care is the top operating necessity for ensuring quality outcomes," says Gilfillan. "But to be successful in changing the cost trend, you need to help physicians manage the experience of the sickest patients."

So, the Geisinger Health Plan placed case managers in all of the practices to work with patients—especially those with conditions like heart failure, diabetes, and lung disease—to help them be healthier, manage their chronic problems, and avoid emergency room visits, hospitalizations, and readmissions. Case managers also coordinate care across the system, including any services needed at home or at such facilities as hospitals, rehabilitation centers, or nursing homes—although the goal is to keep patients out of these facilities as much as possible.

The fact that the case managers are based in the physician's office makes a big difference in their ability to connect with patients. "We've found that more than 80 percent of patients in our medical home practices have engaged with their case managers," notes Gilfillan. "That's much higher than what you find with disease management programs typically offered by health plans, which typically see 20 percent of the patients who would benefit from case management."

The right incentives also need to be in place to get physicians thinking along the lines of managing health for a population of patients. To that end, Geisinger adjusted the way it pays its primary care physicians. Practices that achieve savings (by reducing hospital admissions, unnecessary tests, or other utilization) and also meet a checklist of quality goals receive a share of the savings generated. The payment incentives encourage efficiency, but not at the expense of quality. The remainder of the savings go to the health plan, which funds the services required to support the medical home model.

Results Generate Returns

Geisinger system and health plan executives sit down each month to monitor how well the model is working and where improvements might be needed. "We evaluate how we're doing in terms of quality and outcome metrics. We look at how many people went to the emergency room and whether anyone was admitted, or readmitted, to a hospital. If so, we look at what we could have done differently to avoid the need for these more costly, higher-level services," Gilfillan explains.

So far, results are positive. "We've seen improvements across all three dimensions—quality, experience, and costs. And, because the savings generated have exceeded the investment required, we have had a significant positive return on investment," says Gilfillan.

Making It Work

Geisinger has had a distinct advantage in transitioning to a medical home model in that the health system, physician practices, and insurance arm share common governance. "It helps that we can sit down with just three people, representing the Geisinger Health System, Geisinger's physician group, and Geisinger Health Plan, to set strategic goals, decide on an initiative, and have control of the whole process," says Gilfillan.

But that level of integration is not an absolute necessity for pursuing a medical home model. A healthcare or physician organization interested in the model doesn't need to own a health plan to make it work, but it does need insurers as partners. The insurer brings a population perspective that primary care practices typically do not have, and can provide data, population management tools, nurses, patient care managers, and funding to support the model.

Similarly, the model works just as well with employed or non-employed physician practices, as long as the right tools, resources, and support are provided. In fact, Geisinger's model is in place and working quite well at five practices that are not owned by the system.

"The foundation of a good medical home model is the agreed-upon strategic intent to do it," advises Gilfillan. "Healthcare organizations, physicians, and payers that recognize the benefits of the model should seek each other out and try to develop community approaches that make sense and improve value."

"Frankly, there isn't anything terribly unique about our model other than that we were willing to make a leap of faith," Gilfillan continues. "We were willing to believe that this would work, and we made the investment. Now that we are seeing positive returns and benefits to patients, we hope that leap of faith is no longer necessary. Other organizations can see from our results that the model results in better care, better outcomes, and lower costs, and it is indeed worth the investment." ❍

Source

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