Utilizing the Medical Home Model for Chronic Care Management - Geisinger's ProvenHealth^{SM} Navigator

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Objectives

- Core components of PHN model at Geisinger
- Lessons learned from implementation
- Quality and efficiency outcomes
- Strategies for implementation in other health plans/systems

Overview of Geisinger System

- Geisinger Clinic:
  - 750 Physicians
  - 42+ Community Practice Sites
- Three Acute Care Hospitals:
  - Geisinger Medical Center
  - Geisinger Wyoming Valley
  - Geisinger South Wilkes-Barre
- Geisinger Health Plan:
  - 80 Hospitals
  - 17,000 Providers
  - 227,000 Members

It Takes a Partnership: Each Party Does What It Does Best…

GHP

- Population analysis
- Align reimbursement
- Finance care
- Engage member and employer
- Report population outcomes
- Take to market

Clinical Enterprise

- Identify best practice
- Design systems of care
- Educate member
- Deliver care
- Report pt. outcomes
- Continually improve

To Get Value, Someone Needs to be Charged with Producing It!

- A value driven care vehicle is central
- This vehicle could drive value focus in other components of the system
- Value based incentives are key

ProvenHealth Navigator Objectives

- Improve patient experience, health status and efficiency
- Transform primary care from transaction to value focus
- Act as Value Vehicle (Integrator) to improve quality and efficiency across the spectrum of care

Roll-out over the past 18 months

- Phase 1 January 2007
  - 2 GHS Primary Care Sites
    - 3,000 Medicare Advantage members
  - 1 non-GHS PCP Site
    - 1,000 Commercial & Medicare members
- Phase 2 October 2007
  - 8 GHS PCP sites
    - 9,000 Medicare Advantage members
    - 12,000 Medicare FFS beneficiaries
- Phase 3: July 2008
  - 8 additional sites
    - 5,000 Medicare Advantage Members
    - 7,000 Medicare FFS beneficiaries
- Total as of 2009
  - 35,000 Medicare lives
  - 15,000 Commercial members

Five Functional Components

- Patient Centered Primary Care
- Integrated Population Management
- Value Care Systems
- Quality Outcomes Program
- Value Reimbursement Program

Patient Centered Primary Care

- Patient and family engagement & education
- Physician-led team based care
- Acute/chronic illness care
- Access for expanded scope of services
- Responsibility and awareness of where patient is at all times
- Chronic disease and preventive care optimization via IT enabled planned visits

Integrated Population Management

- Population profiling and segmentation
  - Predictive Modeling
- Health promotion
- Case Management on site
  - Patient specific intervention plans
- Disease Management
- Remote monitoring
  - HF and transitions of care
- Pharmaceutical management
  - Donut-hole

Embedded Case Managers are Key to Success

- Embedded Case Manager (per 700-800 Medicare pts)
  - High risk patient case load 15 - 20% (125 - 150 pts)
  - Beyond disease education
- Personal patient link
  - Comprehensive care review – medical, social support
  - Transitions follow up (acute/SNF discharges, ER visits)
  - Direct line access – questions, exacerbation protocols
  - Family support contact
- Recognized site team member
  - Regular follow ups high risk patients
  - Facilitate access – PCP, specialist, ancillary
  - Facilitate special arrangements (emergency home care, hospice care)
- Linked to Remote & Tele-monitoring for specific populations

Value Care Systems

- Micro-delivery referral systems
  - High volume specialties
  - Ancillary services – Radiology, Lab
- 360 degree care systems
  - Hospital care
  - Home Health
  - SNF's
  - ER coverage
  - Community resources

Quality Outcomes Program

- Patient Satisfaction
- Chronic Disease Metrics
  - Diabetes
  - CHF
  - Coronary Artery Disease
  - Hypertension
- Preventive Services Metrics
  - HEDIS, influenza and pneumococcal

Value Reimbursement Program

- Fee For Service
- P4P payments for quality outcomes
- Practice transformation stipends
  - PCP
  - Practice
- Value Based incentive payments
  - Opportunity based on efficiency results
  - Payments based on quality metrics

Initial Results are Excellent

- Quality – improved outcomes
  - Improvement in diabetes, CAD and preventive care measures
  - Timely follow-up post hospitalization
  - Increase in overall encounters
  - Heart Failure plan of care
- Efficiency – improved medical trend
  - Lower admission rates
  - Lower hospital days
  - Lower readmission rates
  - Lower overall medical expense

Lessons Learned Along the Way

- *It is possible to improve patients' health and dramatically reduce costs*
- Requires change in primary care delivery model; the change is not easy
  - Needs active, engaged providers
  - Needs active, empowered team
- Transitions of care create specific gaps and opportunities
- Patients with very complex conditions need very close follow-up through every system of care
- Critical to have case manager embedded in primary care site

Cautions

- Big investment = big gain on entire population
- Early savings come from focus on managing sickest patients
- Our market is inefficient – Dartmouth Atlas
- Medicare presents more obvious opportunities than commercial

Can Others Do This?

- YES
- Engaged provider/team
  - Gets the bigger picture
  - Committed to new way of practice
- Payor
  - Investment
  - Data
  - New reimbursement model

Don’t need the EMR

Questions or Comments?

Thank You