



Key Points: Strengthening Primary Care for Patients Health Plan Innovations in Patient-Centered Care

The issue:

- Weaknesses and inefficiencies in the current primary care system frequently leave consumers dissatisfied with their care, often leading people to bypass primary care altogether.

Our findings:

- ACHP member organizations understand that strengthening primary care in the context of a “medical neighborhood,” in which care is coordinated across providers and health agencies, improves patient satisfaction and health outcomes, reduces health disparities across a population and lowers costs.
- Health plans can be invaluable partners to physician practices aiming to transform their delivery of primary care by providing funds to support investments in health information technology and new staff; convening practice collaboratives to spread innovations and best practices; and developing new payment and reimbursement models that reward comprehensive care.
- Due to their close relationships with providers and knowledge of local health systems, ACHP members are uniquely positioned to pull together the resources of numerous organizations into an improved system that strengthens care for the people within the community they serve.

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America’s best at delivering affordable, high-quality coverage and care.

The community based and regional health plans and provider organizations from across the country that make up ACHP’s membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care.

To learn more about ACHP, visit us at www.achp.org.

Health Plan Innovations in Patient-Centered Care: Strengthening Primary Care for Patients, a report by the Alliance of Community Health Plans, found that health plans can strengthen organized systems of care through primary care transformation¹ and can ensure that such transformation is *successful, sustainable and scalable* by focusing on *three core elements*: collaboration with provider partners; sharing of tools and resources with practices; and building on the existing cultures and characteristics of the health plan, providers, patients and community.

Outcomes:

All 17 ACHP member organizations profiled increased care quality, improved patient and/or provider experience or lowered costs. Many did all three, demonstrating that health plans and provider groups do not have to sacrifice quality and patient experience for cost.

The Bottom Line:

- Health plans play a vital role in the success of primary care transformation.
- Focusing on coordination and continuity of care, and rewarding quality and efficiency, benefits consumers and the entire health care system.

¹ This brief uses the phrase “primary care transformation” as an umbrella term to describe changes made at the practice level combined with payment reform (described as “comprehensive payment for comprehensive care”) to improve the delivery and experience of primary care. The ultimate goal of primary care transformation is to implement reforms that fundamentally change the delivery and experience of primary care in a community, with a focus on ensuring sustainability over time.

A Sampling of Plan Results:

Capital District Physicians' Health Plan (Albany, New York): An independent analysis of the pilot program found \$8 PMPM cost savings, a 15 percent reduction in hospital inpatient admissions and a 9 percent reduction in emergency department visits, along with fewer advanced imaging tests and decreases in admissions for ambulatory care sensitive conditions.

Capital Health Plan (Tallahassee, Florida): For its Center for Chronic Care, Capital Health Plan, in comparison to baseline assessments, decreased days spent in inpatient care by 40 percent, emergency department utilization by 37 percent and claims costs by 18 percent.

CareOregon (Portland, Oregon): Even though hospital admissions in the clinics chosen for CareOregon's Primary Care Renewal initiative were initially almost 1.5 times higher — and rising at a faster rate — than in non-PCR clinics, the launch of the model reversed these trends. After the one-year implementation period, hospital admissions began decreasing more rapidly in PCR than non-PCR clinics, and as of April 2011 had decreased to the non-PCR rate.

Geisinger Health Plan (Danville, Pennsylvania): ProvenHealth Navigator (PHN) implementation was associated with 36 and 7 percent reductions in hospital admissions and readmissions, respectively, for Medicare Advantage patients, and \$3.7 million in net savings. Geisinger Health Plan members who receive care in PHN sites are likely to have statistically significant better results in many HEDIS measures including immunization rates, diabetes, lipid and hypertension control, as well as appropriate therapies for COPD and asthma.

Group Health Cooperative (Seattle, Washington): Two peer-reviewed studies of the PCMH pilot site showed \$54 PMPM savings from a decrease in emergency department utilization and an overall return on investment of 1.5-to-1 for total medical home costs.

Group Health Cooperative of South Central Wisconsin (Madison, Wisconsin): The plan noted improvement in 17 of 18 measures across five domains related to patient, provider and staff satisfaction as well as in outcome measures like continuity of care and access.

HealthPartners (Minneapolis, Minnesota): HealthPartners reported a 39 percent reduction in emergency room utilization, a 24 percent reduction in hospital admissions and 40 percent fewer re-hospitalizations than community norms. Over four years, HealthPartners Medical Group patients increased the number of patients receiving optimal diabetes care by 129 percent.

Independent Health (Buffalo, New York): Between 2008 and 2011, the plan's PCMH pilot practices had 15 percent lower costs associated with ED utilization than their non-

PCMH counterparts. In addition, they demonstrated a 19 percent increase in generic statin prescribing. Overall, the 18 pilot practices saw a 10 percent decrease in overall cost, corresponding to \$2.9 million in savings.

Kaiser Permanente (Oakland, California): Between 2004 and 2012, colorectal and breast cancer screenings at the *Southern California Permanente Medical Group* increased 36 percent and 11 percent, respectively; blood pressure control increased 43.5 percent; tobacco counseling increased 17 percent; and glucose control in diabetics increased 13.5 percent. Leadership estimate that the medical group's rigorous program for PAP smears may have saved at least 100,000 office visits in 2012; overall, the care delivery transformations are estimated to save more than 15,000 lives over ten years.

Since the introduction of *Colorado Permanente Medical Group's* panel management initiative, the percentage of routine visits with each patient's primary care provider has increased from 50 to 83. Over four years, the *Hawaii Permanente Medical Group* improved its scores on disease management, LDL cholesterol level, blood pressure control and breast cancer screening HEDIS measures from the 50th to the 90th percentile.

Martin's Point Health Care (Portland, Maine): The organization's practice transformation initiative reduced uncontrolled hypertension from 43 percent of patients with elevated blood pressure to 14 percent between 2007 and 2010 in one clinic. It has also been able to increase patient confidence in their ability to manage and control their health problems and keep the medical expense trend low, to half of the national average.

Presbyterian Health Plan (Albuquerque, New Mexico): One of the health plan's PCMH sites reduced ED visits for Medicaid members by more than 11 percent. The Presbyterian Medical Group also reduced ED visits for its Medicaid and Medicare patients, in addition to improvement in quality measures across PCMH sites.

Rocky Mountain Health Plans (Grand Junction, Colorado): A 12-month analysis of the first two groups of practices engaged in the Colorado Beacon Community program, for which Rocky Mountain Health Plans is the lead grantee, found increases in patients with low cholesterol (39 to 53 percent), increases in tobacco counseling (from 25 to over 50 percent of patients) and increases in depression screening for diabetes.

UCare (Minneapolis, Minnesota): For Medicare, Medicaid and dual-eligible patients at Lakewood Health System, the plan reported a 37 percent decrease in the total cost of care and an 18 percent decrease in inpatient admissions.

UPMC Health Plan (Pittsburgh, Pennsylvania): The plan has reported reductions in readmissions and costs, totaling a return on investment of 160 percent, and increases in quality and efficiency among its PCMH practices.

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