Strengthening Primary Care for Patients:

Capital Health Plan | Tallahassee, Fla.

Background

Capital Health Plan is a nonprofit, mixed-model health maintenance organization serving Tallahassee and the surrounding area, with over 125,000 members. Capital Health Plan focuses on delivering evidence-based care under the direction of primary care physicians in an effective, timely and cost-effective manner, and is proactive and innovative when it comes to improving the health of the community.

In collaboration with a large local hospital and its affiliated health system, the health plan sought to improve the care delivered to the sickest one percent of their membership, a group that represented 25 percent of the health plan's total cost expenditures.[1] To do so, Capital Health Plan developed and put into operation a high-risk primary care clinic, the Center for Chronic Care, exclusively for Capital Health Plan members with severe health risks.

The number of patients per physician at the Physician Group of Capital Health Plan is determined by the patients' risk scores. Physicians who care for patients with higher risk scores have smaller panels. When a provider has relatively healthier patients, she or he is given more patients. All physicians at Capital Health Plan, including those in the center, are capitated, with pay-for-performance incentives.

Initiative Title: Center for Chronic Care
Start Date: 2003
Practices: 1
Physicians: 2
Covered Lives: 550

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, including patient care coordination, patient-centered medical homes, accountable health care delivery and use of information technology.

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Implementation

Using predictive modeling software, the plan identified an initial cohort of approximately 250 patients and sent letters to the individual members and their primary care physicians. The letters informed both parties of the opportunity to receive care at the new center which, in 2003, consisted of a single gerontologist, two nurses and a clerical support staff member. As of 2013, Capital Health Plan was able to support two full-time physicians at the Center for Chronic Care who, together with their support staff, manage a panel of approximately 550 patients.

Patient-Centered Care and Coordination

The Center for Chronic Care, in pursuit of a comprehensive and planned approach to care, addresses the whole patient at every visit and engages the patient in self-management. New patients take part in a detailed intake process, which includes a multidisciplinary review of medications, diet and baseline emotional, social and physical well-being. In conjunction with the patient's medical history and weekly goals, this information is used to create a patient care plan that is updated regularly. The center also offers open access with same-day visits that take as long as necessary.[1]

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Centralized health plan nurse care coordinators interface with the center and other practices to perform complex care management. They have access to patient information through the practices' electronic medical records (EMR) and hospital records. Care is also coordinated at the center level, where the nurse leader organizes each appointment and the initial intake.

Supporting Integration

Capital Health Plan created and integrated a simple spreadsheet in the hospital EMR, so that a "red flag" alert pops up when a center patient arrives or is admitted at a Capital Health Plan-affiliated emergency department. This indicator alerts the hospital staff that a certain patient has complex medical needs and a care plan; the hospital staff is therefore better prepared to reconcile all medications at admission and discharge and provide care consistent with the patient's history and care plan. Upon discharge, each hospital provides detailed discharge information to the center.

The health plan implemented a computer-based medication reconciliation program called Healthcare Passport to store patient information in a web- and paper-based format as well as on a physician intranet site. Capital Health Plan also coordinates a chronic care steering committee consisting of physicians, nurses, patients and health care professionals from the health plan and hospital.

Sustainability

Capital Health Plan has spent years nurturing a high-efficiency, high-quality physician group through its use of education and mostly non-monetary incentives. The plan has found that, due to the effort it has spent developing its physician culture, providers who move into its staff model tend to improve both their quality and efficiency. With this close relationship and mutual trust between the plan and providers, practitioners drive changes in care delivery — rather than receiving top-down instructions from the health plan — and new staff physicians who join Capital Health Plan bring their own unique approaches.

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Capital Health Plan does not dictate how physicians should practice in the Center, nor has it adopted the National Center for Quality Assurance's (NCQA) Patient-Centered Medical Home (PCMH) model; instead of describing specific ways physicians should improve care, it takes advantage of the diversity, personality and training of providers to tweak the center's care model. Most of the process changes over time have therefore been driven by physicians.

The plan, however, is prescriptive about desired outcomes, and relies on physicians and their teams to figure out how to achieve those outcomes and share best practices with each other. It has found that this process reliably leads to simultaneous improvements in quality of care and provider efficiency.

Outcomes

Capital Health Plan provides the center with a clinical dashboard, which reports on quality, efficiency and access measures, such as Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Through the health plan provider portal, physicians also have access to additional data such as pharmacy claims. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) staff survey is used to assess staff satisfaction.

Patients who receive their care at the Center for Chronic Care are, on average, seen by their new primary care physician 3.5 times more often than before switching to the center. In comparison to baseline assessments, the center has decreased days spent in inpatient care by 40 percent, decreased emergency department utilization by 37 percent, increased pharmacy costs by 22 percent, decreased claims costs by 18 percent and decreased the mortality rate from 6.50 percent to 3.96 percent. In 2004, per member per month (PMPM) costs were reduced by 21 percent (from $1,179 to $932) and in 2005, for a second cohort of patients, PMPM costs were reduced by 65 percent (from $2,869 to $993).[2]

Average costs for commercial members receiving care at the center were $24,643 in 2011 compared to predicted average costs of $28,031. The health plan also decreased actual costs for Medicare patients at the center to $19,941 per Medicare patient in 2011 compared to an average predicted cost of $22,145. The center has therefore realized an average return on investment of 1.6-to-1.[3]

Scale

As of January 2013, Capital Health Plan had no plans to scale the Center for Chronic Care to other areas.

Over time, the center has changed the way it selects patients. Instead of just choosing the highest-risk patients, health plan staff makes more of an effort to find patients who have a desire and will to improve. The center has also moved away from accepting patients who are in the last few months of life and instead focuses on palliative care for those members, which is more in line with its goal to optimize care for patients who can improve their health. Patients with cancer or who are on dialysis continue with their course of care and are followed closely by their specialists.

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[1] Goodell, Sarah; Bodenheimer, Thomas and Berry-Millet, Rachel. "Care Management of Patients with Complex Health Care Needs." *Robert Wood Johnson Foundation*. 19 (2009).
[2] "Report from Tallahassee Memorial HealthCare on Enhancing Continuity of Care." Institute for Healthcare Improvement. August 2011.
[3] Alliance of Community Health Plans. "Investing in Outcomes, Creating Value: Capital Health Plan." October 22, 2012. Available: <http://www.achp.org/members-publications/capital-health-plan-case-study/>

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

MAKING HEALTH CARE BETTER
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