

Building an Advanced Medical Home to Improve Chronic Care Outcomes

PATRICIA DONOVAN: This is Patricia Donovan for the Healthcare Intelligence Network. Today I am speaking with Dawn Bazarko, senior vice president of clinical innovation for UnitedHealthcare. Dawn is presenting at HIN's Webinar on "Building an Advanced Medical Home to Improve Chronic Care Outcomes". Thanks for joining me today Dawn.

DAWN BAZARKO, SENIOR VICE PRESIDENT OF CLINICAL INNOVATION FOR UNITEDHEALTHCARE: Hi. Good morning Patricia. Happy to be here.

PATRICIA DONOVAN: To begin with much of the work we've been hearing about in the advancement of the medical homes model to date has been done for the medically underserved. And I understand that you recently launched this initiative, but what's the single greatest challenge that you've found in establishing medical homes for commercial population? How would your approach differ perhaps from a program aimed at Medicaid beneficiaries?

DAWN BAZARKO: As we've developed our medical home pilot approach I think we've learned a lot about how best to structure our work with our physician network as well as with consumers who may benefit from this type of a care delivery model. Most commercial health plan beneficiaries today no longer elect a primary care physician and that was really based on decisions and consumer feedback that the gatekeeper model restricting access to care is highly undesirable. While the medical home is not a gatekeeper construct, the challenge will be educating consumers about the features and benefits of a medical home while positioning this

differently than a gatekeeper HMO, which was found to not be appealing to consumers and was seen as they indicated as care restrictive in the past. Patients need to be actively engaged in their care experience and in fact, the patient plays a very important role in maximizing the potential benefits offered by the medical home to receive higher quality and more affordable healthcare and really an overall more satisfying care experience.

As more and more consumers share proportionally higher percentages of their healthcare costs issues around selecting higher quality higher value medical services are paramount and approaches that we're considering that might differ from those taken for the medically underserved including supporting those with benefit design structures that incentives medical home care choices, effective self management and management of risk factors to improve overall health and well being. The overall aim is to implement the preventative and chronic care model and not just focus on disease, but also disease prevention, which similarly leverages the community and all aspects of the care system to operate in a very different way based on the unique needs and wants of the patient. I would argue that the principals sought in treating the underserved are the same in a commercial population, but there may be more levers to pull relative to use of benefit design incentive, patient activation tools, partnerships with care and disease management programs etc. Overcoming the gatekeeper HMO hangover and perception issues around restriction of care may be the major public relations challenge. The term medical home also is not well understood by consumers. So naming and marketing the features and benefits of the medical home will be very important.

PATRICIA DONOVAN: Thank you Dawn it sounds like a lot of the responsibility is going to be on the patient going forward?

DAWN BAZARKO: I would characterize it as joint responsibility, shared responsibility.

PATRICIA DONOVAN: You mentioned a little bit the use of incentives and as I understand it from your pilot the physicians who participate will receive enhanced payments for providing a level of care that's consistent with the tenets of the medical home, which include care, self management, prevention and behavioral health, which are some of the things you just mentioned in relation to patient's responsibilities. How will these requirements affect the traditional patient encounter? Are we going to see more physicians going on line to communicate with patients to deliver the medical home model of care?

DAWN BAZARKO: Well certainly medical homes should establish physician guided personal and intimate relationships with their patients, and fundamentally change the service model offered to their patients in addition to the enhanced care model. I think that's one of the distinguishing features is a medical home that is comprised of simply technology and enhanced structure and process really doesn't deliver on I think what patients really want in a different care relationship. And that is to have a service relationship with their physician guided physician led care team. So things like providing enhanced access and improved communications will require the medical home to try new and improved ways of staying connected with patients to include things like, as you've indicated, secured email and new mechanisms of offering care virtually. This may also include offering things like group visits for cohorts of patients that

may have chronic disease such as diabetes. The medical home will also be instrumental in promoting patient self-management and offering tools and resources to engage patients around these care opportunities. The medical home will provide more proactive outreach to patients and offer a more comprehensive well-planned care visit. One very exciting opportunity in the medical home is improved comprehensive and coordinated care for patients with medical and behavioral comorbidities such as the patient with diabetes and depression. So through improved screenings and use of tools such as the PHQ9 early identification of depression and improved coordination with behavioral health resources as part of the medical home care team holds real promise to really impact health outcomes, improve productivity and overall healthcare costs. The medical home will need to develop new ways as I indicated earlier of marketing their services and value added features to consumers to distinguish themselves as the medical care quarterback in a trusted and responsive care facilitator.

PATRICIA DONOVAN: Thank you Dawn. If I could just follow up on that, how is the typical primary care physician going to be equipped to address the behavioral healthcare needs say for example the diabetic patient that you just mentioned to deliver that primary care and address the behavioral health issue?

DAWN BAZARKO: Well as we've looked at our data a large part of behavioral health issues are currently being addressed in primary care. So about 70% of psychotropic medications are prescribed by primary care physicians. So today a number of patients are really going to their primary care physician to receive care for these behavioral health needs. I think what we're envisioning in the medical home, a model and support to

the primary care practices that will serve in our pilots is enabling them with more information at the point of care, tools and resources that we can bring to bear to support their serving these patients, pharmacy information etc, so that they are optimized given they deliver a lot of these services today to care for these unique and complex needs of the patient population.

PATRICIA DONOVAN: Thank you Dawn. And finally I know the focus of this upcoming webinar is on chronic care, but do you think that this pilot program can also have an effect on the number of members seeking emergent care at emergency rooms?

DAWN BAZARKO: Yes we see significant opportunity to impact not only non urgent emergency care visits, but also to impact inpatient readmission rates through improved care coordination and care transition management. As the medical homes enhanced access and improved management of comorbidities, such as anxiety and depression as we talked about earlier, we anticipate improved symptom management dealing with issues such as medication reconciliation and improved pharmacy management and the ability to better manage clinical and behavioral health issues.

Studies also indicate that the more care providers one has in their lives the more opportunity for patient safety errors, redundancy in tests and services and overall care fragmentation all of this leads to poor quality worse health outcomes and higher costs. In addition to the improved capabilities offered by the medical home, tighter coordination and information exchange with ER facilities to ensure primary care follow up post event, and optimized care engagement set in motion care

really impact subsequent ER visits. So we really see the medical home as one way to help solve these issues. Also, to improve access to communication and use of health information exchange and improved care experience at the right place with the right care provider can be enabled.

PATRICIA DONOVAN: Why thank you Dawn. Those are all the questions that I have today. And were looking forward to hearing from you during the webinar.

DAWN BAZARKO: Thank you very much I appreciate the opportunity.