Frequent Touch Primary Care
&
CV Disease Prevention

Lakeland Regional Health Cardiovascular Symposium
02/08/2020

Reyan Ghany, MD, FACC, FASE, RPVI
National Director of Cardiovascular Diseases, ChenMed
Regional Market Chief Medical Officer – IL, LA, KY, Tampa North
reyan.ghany@chenmed.com

ChenMed | Chen Senior Medical Center | JenCare Senior Medical Center | Dedicated Senior Medical Center
A CHENMED COMPANY

After viewing this presentation, you should be able to:

- Define High Touch Care
- Define Value-Based Care
- Have a better understanding of what value-based care is
- Appreciate the difference between a value-based high-touch model versus a standard model and the impact on hospitalization and cost

- 46 million people are 65 years or older.
- Elderly population is expected to double by 2030.
- Caring for chronic conditions in this age group costs the United States more than $617 billion per year.

- High-intensity care is defined as “care provided by a multidisciplinary team for patients with complex conditions to improve care and lower healthcare costs.”

- An emerging name for this model subtype is high-touch care.

The American Journal of Managed Care > September 2018 – Published on: August 28, 2018

High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population

Reyan Ghany, MD; Leonardo Tamariz, MD, MPH; Gordon Chen, MD; Elissa Dawkins, MS; Alina Ghany, MD; Emancia Forbes, RDCS; Thiago Tajiri, MBA; and Ana Palacio, MD, MPH

Study Details

Retrospective cohort study of 2 models of care

Model 1: high touch care model – smaller panel size + more frequent visits.

Model 2 – Standard care model.

Model 1

Chen Senior Medical Centers is a multispecialty organization spread over 8 states.

Its model of care is based on the following pillars:

- A preventive cardiovascular program
- In most states, on-site medication dispensing by providers
- Smaller patient panels of approximately 450 patients per primary care physician (PCP)
- Very frequent encounters, mean of 189 mins/yr. face time
- An advanced electronic health record (EHR) system
- Courtesy transportation for all patients and
- Walk-in hours.

We included all Chen Medical members who had Medicare Advantage plans and were seen in any of the Chen Medical practices between January 2, 2014, and March 27, 2015.

TABLE 1. Comparisons Between Models of Care

Service	Model 1: High-Touch Care	Model 2: Standard Care
Number of offices	>20	3
Preventive cardiovascular program	Yes	No
Electronic health record	Yes, without patient access	Yes, with patient access
Urgent care	No	Yes
Laboratory and imaging	No	Yes
Onsite medication dispensing	Yes	Yes
PCP panel	450 patients	1000 patients
Average yearly face time with PCP	189 minutes	90 minutes
Transportation	Yes	No

PCP indicates primary care physician.

Study Details

17,711 unmatched Medicare Advantage primary care patients included

Matched 5695 patients from both models of care

Charlson comorbidity Index, age + gender were similar between both matched groups (P >.05)

TABLE 3. Propensity-Matched Baseline Characteristics

Characteristic	Model 1: High-Touch Care	Model 2: Standard Care	*P*
n	2356	3339	
CCI score, mean ± SD	0.33 ± 0.72	0.35 ± 0.72	.06
Age, years, mean ± SD	71.1 ± 3.6	71.2 ± 3.5	.07
Female, %	57	59	.16
Number of PCP patient visits per year, mean ± SD	8.7 ± 4.6	3.8 ± 3.8	<.01

CCI indicates Charlson Comorbidity Index; PCP, primary care physician.

TABLE 4. Medication Use in Matched Models of Care

Medication	Model 1: High-Touch Care	Model 2: Standard Care	*P*
Aspirin, %	41	0	<.01
ACE inhibitor/ARB, %	69	33	<.01
β-Blocker, %	39	17	<.01
Statin, %	64	42	<.01
Diuretic, %	51	24	<.01

ACE indicates angiotensin-converting enzyme; ARB, angiotensin receptor blocker.

Primary Outcomes

Primary outcome was healthcare utilization.

Healthcare utilization = total healthcare costs + number of hospital admissions.

We collected medical, pharmacy, hospital admissions during the same 12-month period; and counted all admissions to any hospital.

Secondary Outcomes

A secondary outcome was use of medications.

We defined medication use as refilling at least 1 prescription in each of those medication classes during the study period.

Results

TABLE 5. Healthcare Utilization by Model of Care

Characteristic	Model 1: High-Touch Care (n = 2356)	Model 2: Standard Care (n = 3339)	*P*
Median (95% CI) PMPM total costs removing 5% outliers on both tails, $	87 (26-278)	121 (52-284)	<.01
Number of hospital admissions per year, mean ± SD	0.10 ± 0.45	0.20 ± 0.58	<.01
Median (IQR) PMPM total costs removing 5% outliers on lower tail, $	51 (0-184)	84 (25-269)	<.01
Adjusted mean (95% CI) PMPM costs, $	361 (105-956)	435 (206-1356)	<.01

IQR indicates interquartile range; PMPM, per member per month.

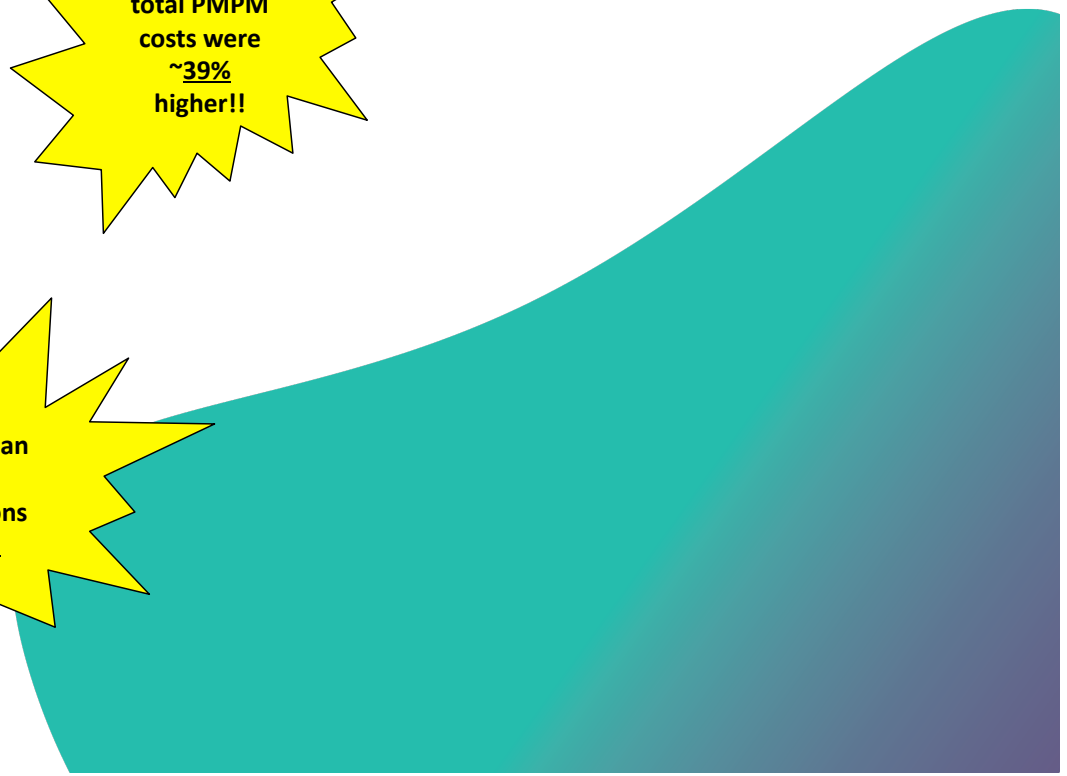
Model 1 vs. Model 2

Median Total PMPM Health Care Costs	
Model 1	Model 2
$87 (95% CI, $26 – $278)	$121 (95% CI, $52 - $284)

Model 2's total PMPM costs were ~39% higher!!

Mean Number of Hospital Admissions	
Model 1	Model 2
0.10 ± 0.40	0.20 ± 0.58

Model 1's mean # of hospitalizations were ~50% lower!!!!!



High-Touch Care

Patients who received high-touch care had:

- Lower healthcare costs
- Fewer hospitalizations
- Had a higher number of encounters between patients and providers
- Was associated with higher use of cardiovascular medications.

High-Touch Care

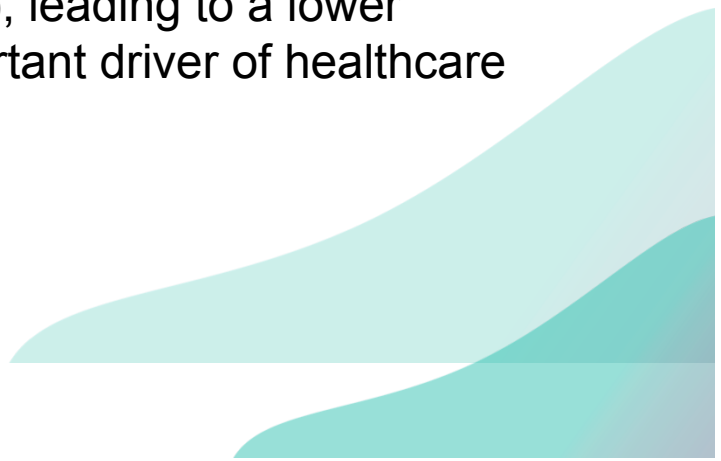
- Greater interaction between patients and providers may allow for better optimization of medications and promote better adherence, leading to higher use of evidence-based medications.

- Our findings support the fact that the high-touch model may lead to higher use of cardiovascular medications known to improve control of blood pressure and cholesterol and reduce cardiovascular outcomes.

High-Touch Care

- Common causes for hospitalization due to common ACSCs include lack of or delayed access to care, suboptimal monitoring, and medication nonadherence.

- A potential explanation for the healthcare cost reduction seen in the high-touch model is that it may allow for the timelier diagnosis of ambulatory care–sensitive conditions (ACSCs), leading to a lower mean number of hospital admissions, an important driver of healthcare costs.



Additionally…

- Another reason may be because patients in the high-touch care model were seen more frequently than patients in the standard care model, they may better adhere to other preventive care strategies, such as vaccinations or cancer screenings.

- Trust in healthcare relationships is a key ingredient of effective and high-quality care. High-touch care can help build the physician–patient relationship, which in turn could lead to greater trust.

Limitations

- We matched for a limited number of factors known to affect the outcomes and could not match for other variables such as cardiovascular risk, social determinants of health, and principal diagnosis. However, we did match for the most important contributors to costs, such as comorbidity burden and age.

- We had access only to claims data for both models of care; therefore, our analysis is subject to information bias.

- The generalizability of the results is applicable only to at-risk practices that care for Medicare Advantage populations.

The Promise of Value-Based Care:
Hope for the Future

Faisel Syed, MD
National Director of Primary Care
faisels@chenmed.com

ChenMed | Chen Senior Medical Center | JenCare Senior Medical Center | Dedicated Senior Medical Center

Learning Objectives

- Understand the four principles underlying the “Primary Care Revolution”[1]:
  - Value Based
  - Relationship Driven
  - Complex integrated care
  - Holistic wellness in addition to sick care
- Have an example of how this has been applied successfully by a full risk Medicare Advantage physician-led, Primary Care provider — ChenMed.
  - Identify the role of clinicians in leading the transition to value-based care delivery
  - Describe the integration of non-face-to-face care
  - Describe effective approaches to team-based workflows that capitalize on value-based care payment
- Brief overview of the new Medicare CMMI – “Primary Cares” models.

Disclosure

I have no actual or potential conflict of interest in relation to this program/presentation.

ChenMed

Who we are

The ChenMed Way

Vision

To be America's leading primary care provider, transforming care of the neediest populations

Mission

We honor seniors with affordable VIP care that delivers better health

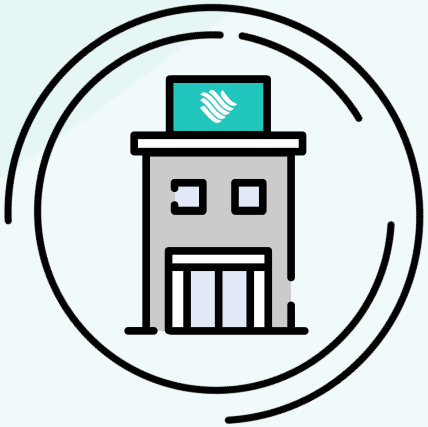
Core

Build and invest in PCP-led care teams that can deliver outcomes

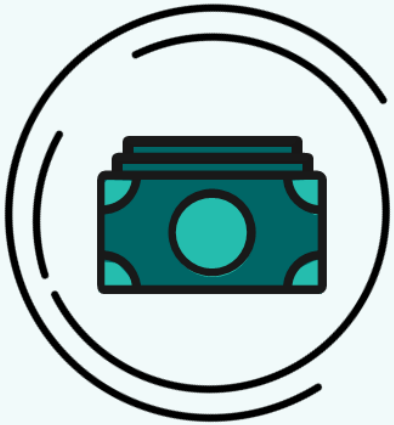
COMMITMENT TO OUR VALUES

- Love
- Accountability
- Passion

What we do



Operate 60+
primary care centers



Take global full risk for
Medicare Advantage
and dual eligible members
in multiple plans

We focus on lower-income,
polychronic seniors
by providing an affordable
“concierge” solution, delivering
superior outcomes

Where we operate

60+ Medical Centers and Growing

Our medical centers are located in primary care shortage areas.

Chen Senior Medical Center

- Ft. Lauderdale, FL
- Miami, FL

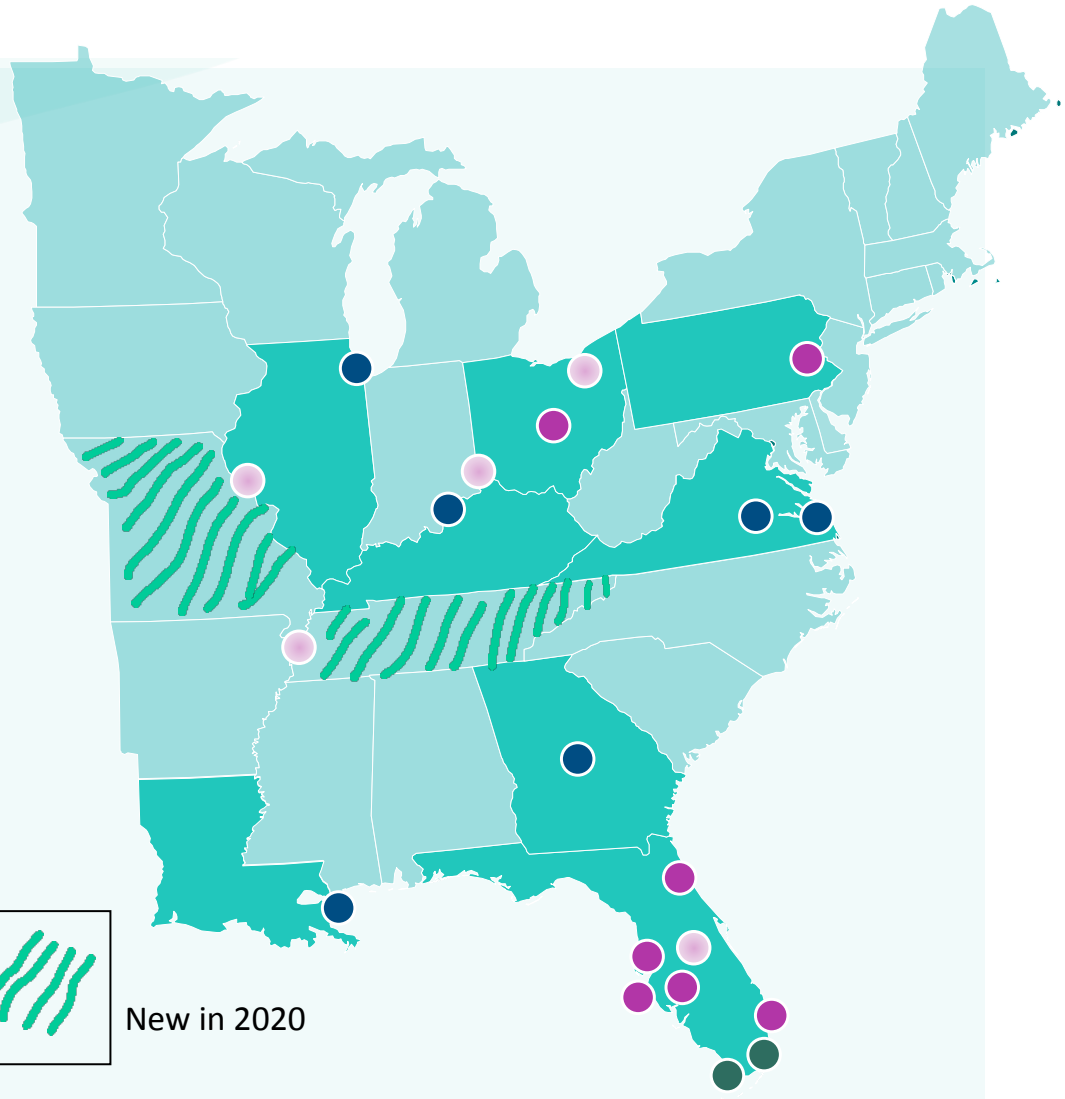
JenCare Senior Medical Center

- Atlanta, GA
- Chicago, IL
- Louisville, KY
- New Orleans, LA
- Richmond, VA
- Tidewater, VA

Dedicated Senior Medical Center

- Bradenton, FL
- *Cincinnati, OH**
- *Cleveland, OH**
- Columbus, OH
- Jacksonville, FL
- Lakeland, FL
- Memphis, TN*
- Orlando, FL*
- Palm Beach, FL
- Philadelphia, PA
- St. Louis, MO*
- Tampa, FL

**Coming soon*



New in 2020

Current State

Health

[redacted] has ruined us': Health system sues thousands of patients, seizing paychecks and putting liens on homes

[redacted] Health System treated Heather Waldron in 2017 for complications from an intestinal malformation. (Griffin Pivarunas for Kaiser Health News/Photo by Griffin Pivarunas for Kaiser Health News)

By **Jay Hancock** and **Elizabeth Lucas**

September 9, 2019 at 11:19 a.m. EDT

. . . . Over six years ending in June 2018, the health system and its doctors sued former patients more than **36,000** times for over **$106 million**, seizing wages and bank accounts, putting liens on property and homes and forcing families into bankruptcy, a Kaiser Health News analysis has found.

BREAKING

[redacted] Health halting patient lawsuits that affected 56,000 over 7 years

___'s in-house physician group filed more than **56,000** lawsuits against patients for **$81 million** over the seven years ending in 2018.

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

ANALYSIS

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

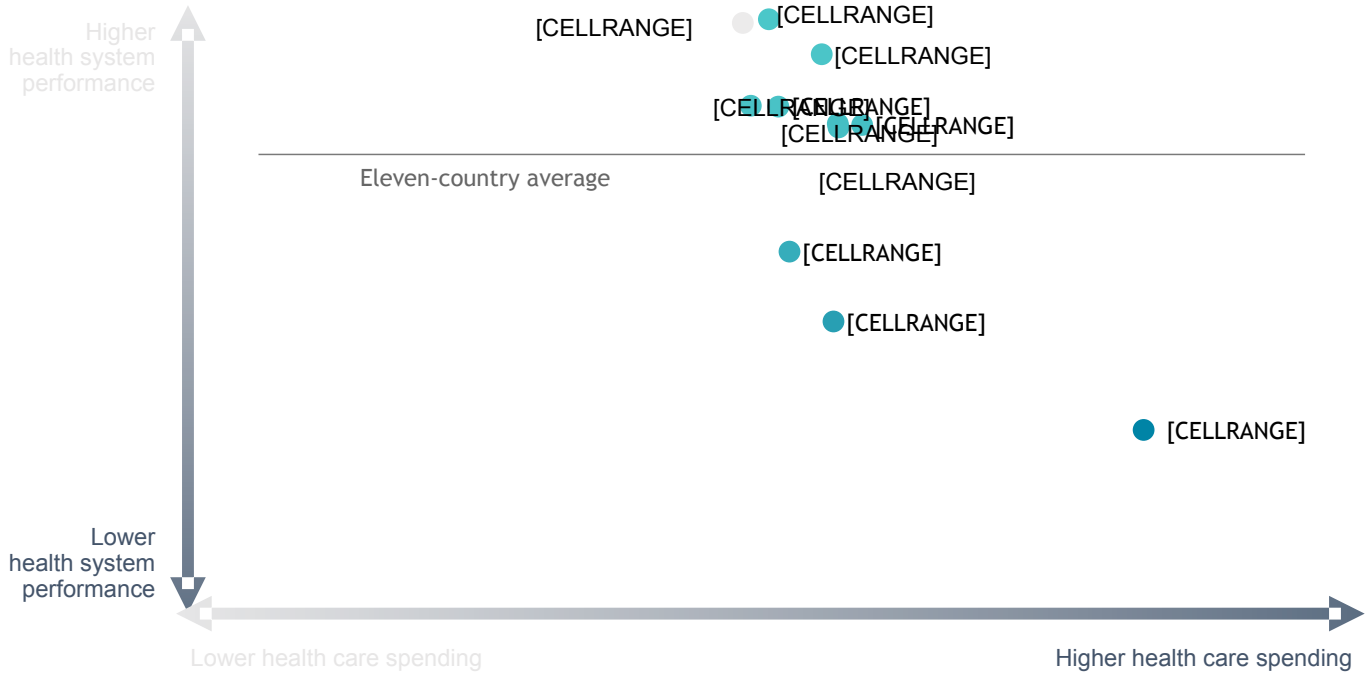
Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA

Relative Risks

1/200 – risk of dying from Hospital Acquired Condition

1/2000 – risk of dying from Skydiving accident

Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP.
Source: Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers.

These Patients Are Hard to Treat

A study examined a popular approach that coordinated care for the most expensive patients, and found that the project did not reduce hospital admissions.

What is missing?

Cooper University Hospital in Camden, N.J. A project in the city to reduce hospital visits by addressing patients' needs outside the hospital did not produce desired results. Mel Evans/Associated Press

https://www.nytimes.com/2020/01/08/health/camden-coalition-chronic-illness.html

The Camden Coalition's Core Model

- uses real-time data on hospital admissions to identify patients who are superutilizers, an approach referred to as "hotspotting."
- Focusing on patients with chronic conditions and complex needs and starting with the premise that navigation of the **standard system** is difficult for these patients, ...

Multidisciplinary team that included:

- registered nurses
- social workers,
- licensed practical nurses
- community health workers
- health coaches.

It is possible that approaches to care management that are designed to connect patients with **existing resources are insufficient** for these **complex cases**.

https://www.nejm.org/doi/full/10.1056/NEJMsa1906848

Current state of Primary Care

Urgent Care
- URI
- UTI

Condition Specific Care
- Dilated Cardiomyopathy
- CHF

Continuity
- HTN
- DM
- HLD

- $50-$150/Visit
- No matter how sick

Complex Chronic Care
- HTN
- HLD
- CAD
- CVA
- PVD
- Addiction
- Hospital Discharge

Well Care
- CRC
- BC
- Flu Shot

Adapted from: Reframing Healthcare: A Roadmap For Creating Disruptive Change by Zeev Neuwirth, MD, 2019

"The creation of **value for patients** should determine the rewards for all other actors in the system… value in healthcare is measured by the **outcomes achieved**, not the volume of services delivered…"

Michael E. Porter, Ph. D
Harvard Business School

4 Principles of Primary Care Revolution

1) Driven by Value-Based Payments – No outcomes, no income.

2) Relationships remain the bedrock of Primary Care – supported by care teams and technology.

3) Physicians will focus on high complexity patients.

4) Prioritize coaching for health vs consulting for sickness

Adapted from: Ellner AL, Phillips RS. The Coming Primary Care Revolution. J Gen Intern Med. 2017;32(4):380-6.

What is Value-Based Care?

- If the health of the patient does well, providers do well
- Financial and professional satisfaction
- “No outcomes, no income” -Dr. David Nash

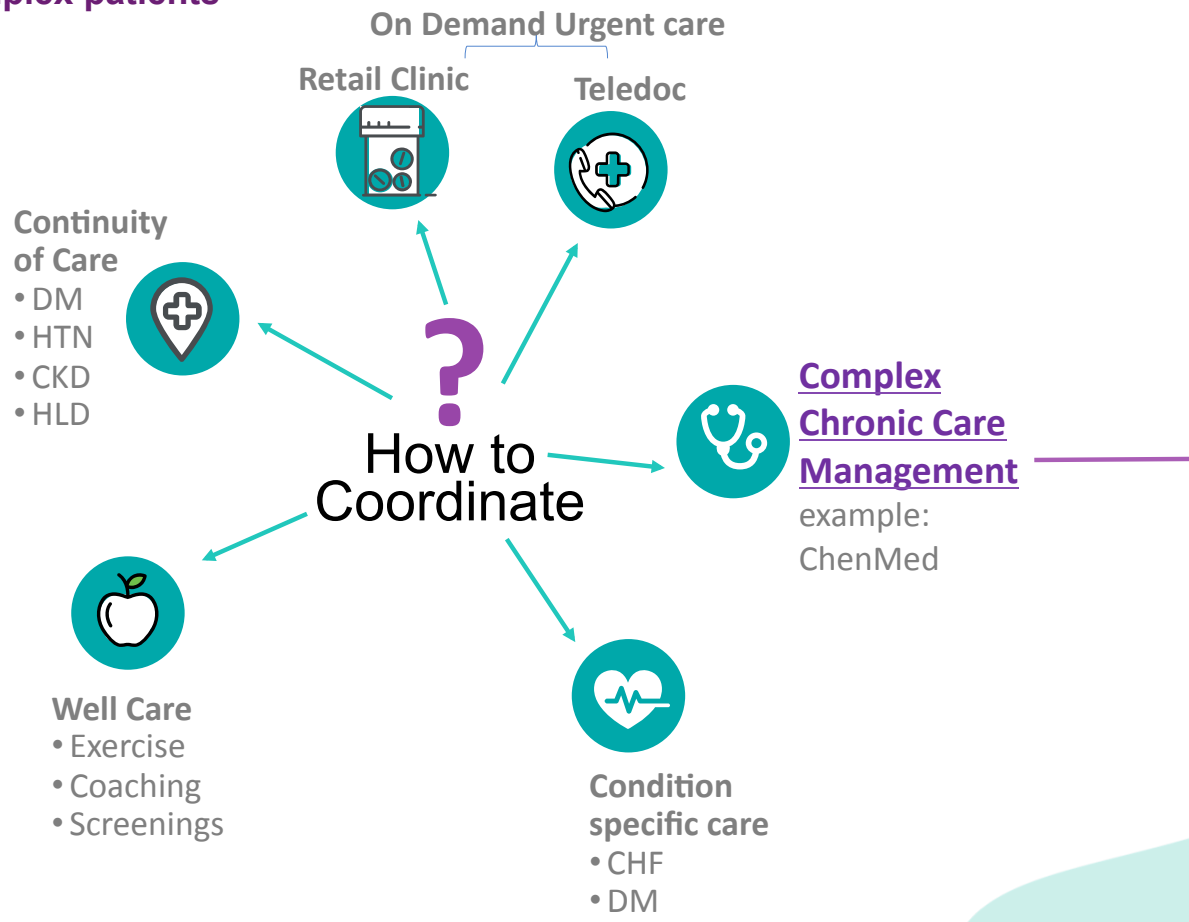
IN THE FULL RISK WORLD

Every patient has our credit card in their pocket

The Doctor Patient Relationship

Analogous to a Row Boat–
“The Doctor and the Patient must each take an oar. ”
– B. Lewis Barnett, MD

Future State of Primary Care—Physicians Focus on Complex patients



ChenMed

- Primary Care
- Walk In
- Cardiology
- Case management
- Transportation
- Behavioral Health
- Acupuncture
- Pharmacy

Adapted from: Reframing Healthcare: A Roadmap For Creating Disruptive Change by Zeev Neuwirth, MD, 2019

Coaching for Health
vs consulting for sickness

Medicare Advantage
Leading the Way

Medicare Advantage

Medicare

A - Hospital | B - Doctors Office | D - Drugs

Government Administered

Government assumes financial risk

Medicare Advantage

A - Hospital | B - Doctors Office | D - Drugs | Supplement(s)

Private Administered

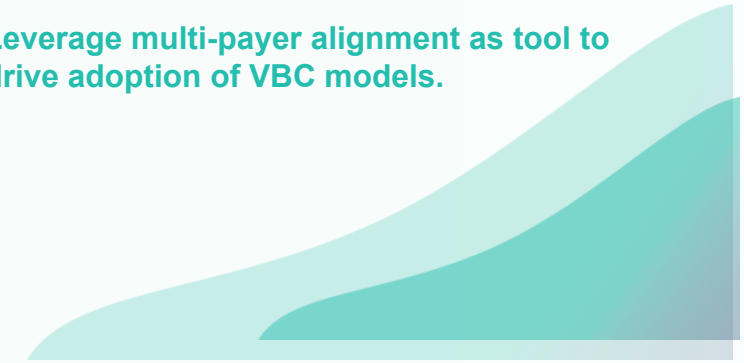
Also, financial risk is assumed by insurer or by provider, but is risk adjusted.

Why is Medicare Advantage Growing?

1. Saves money
2. Profitable for the payer
3. More benefits, improved outcomes & lower costs for the patients
4. Lowers costs for both MA and FFS patients

Primary Care First- Principles

1. Move away from FFS Payment System.
2. Reward Value Based Outcomes over Process.
3. Use Data to Drive Practice Accountability and Performance Improvement.
4. Leverage multi-payer alignment as tool to drive adoption of VBC models.



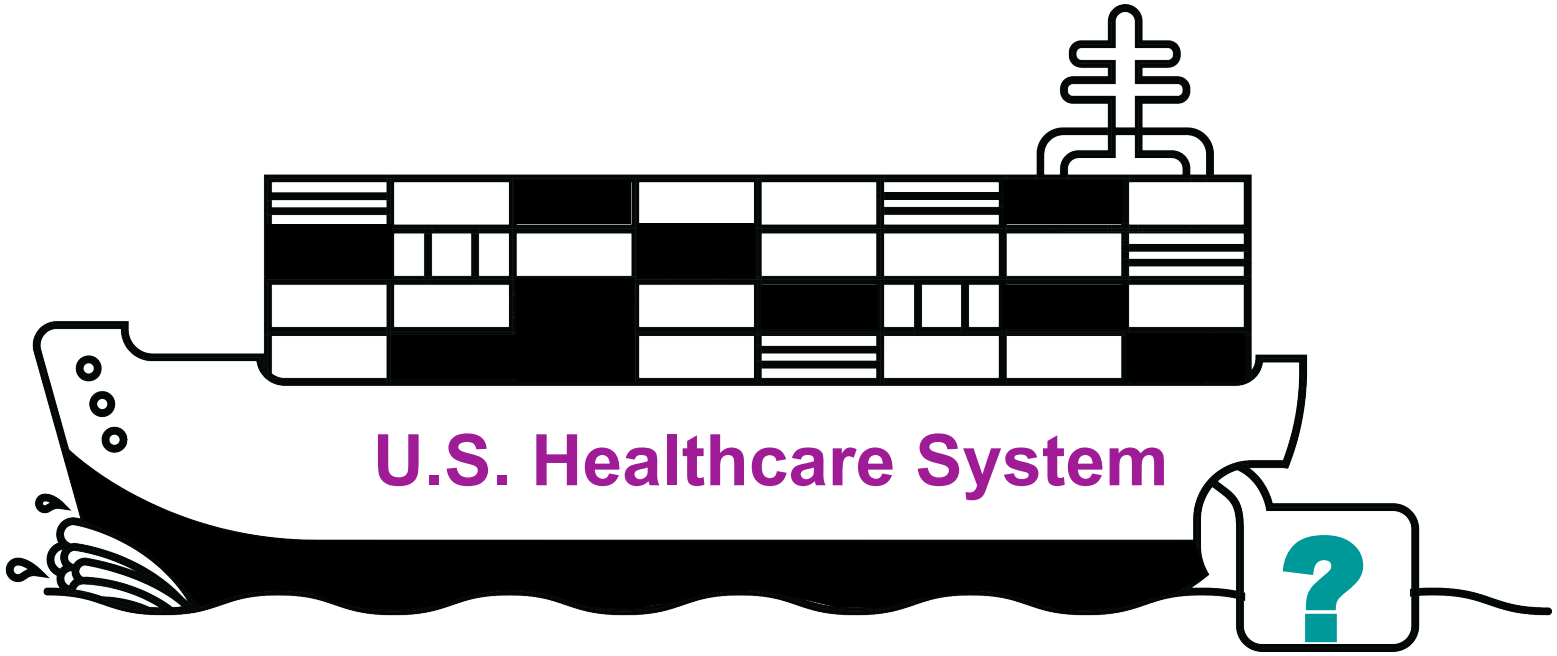
How does *Primary Care First* compare to straight *Fee For Service* world?

Assume 2.5 visits per year (national PCP average)

Palmetto GBA
99213: $ 74.56/ visit
99215: $146.33/ visit
PCF per visit-- $40.82

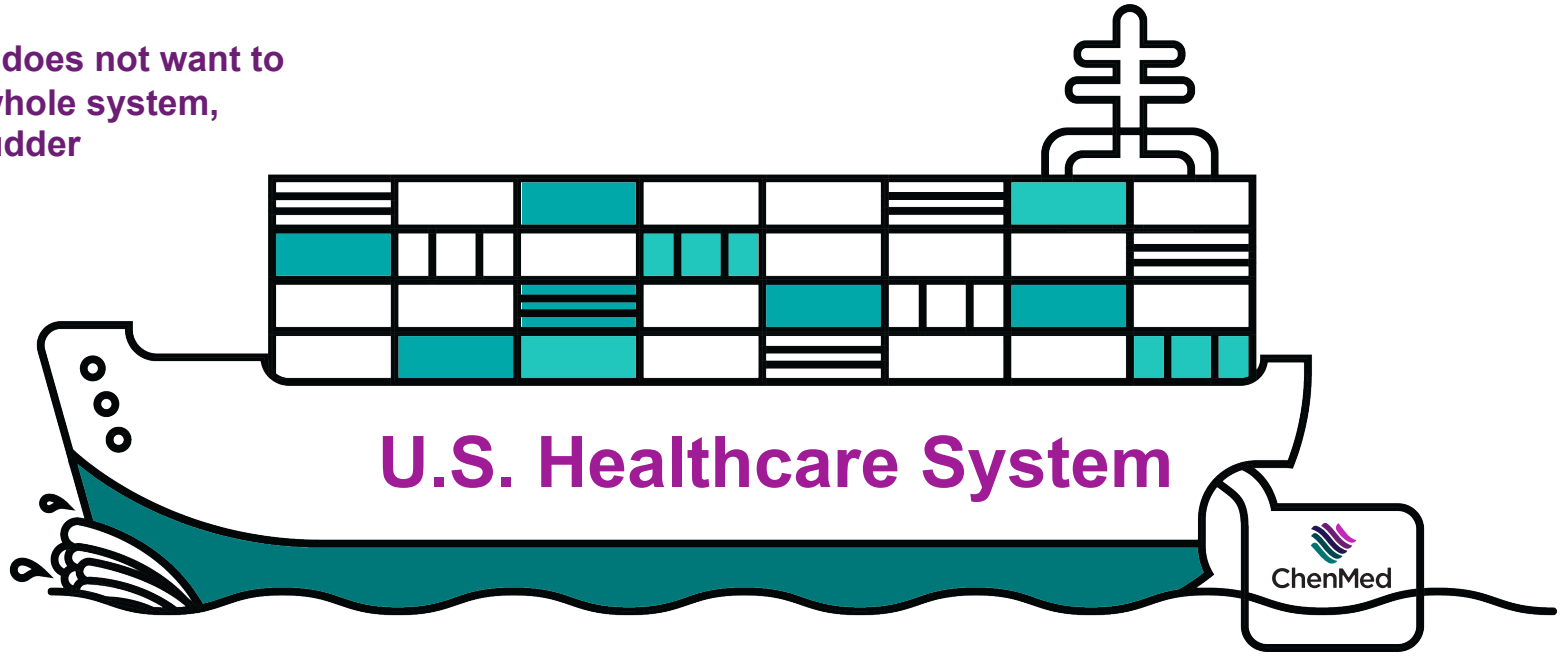
	- Primary Care First -			- Fee For Service -		
	FFS Visit	PMPY	Total Rev/YR	E and M Visit	PMPY	Total Rev/YR
Low Risk	$102	$336	**$438**	$186.40 (99213)	$0	**$186.40**
High Risk	$102	$2,100	**$2,202**	$365.83 (99215)	$0	**$365.83**

- Even with 10% negative penalty for performance– still more revenue $394 and $1982respectively
- Potential positive adjustment –$606 to $3252.00


U.S. Healthcare System
?

The ChenMed Way

ChenMed does not want to own the whole system, just the rudder

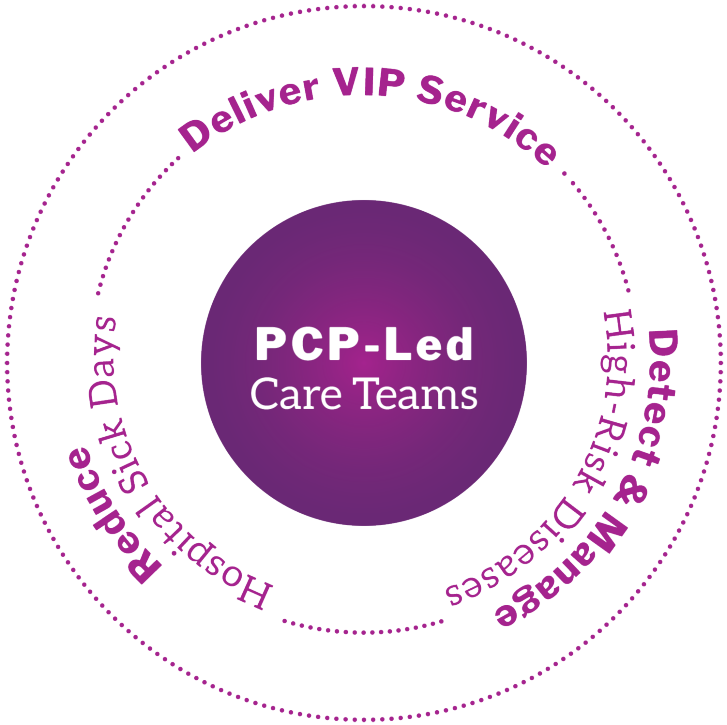


The ChenMed Way

Everyone wins when we achieve our vision to be America's leading primary care provider, transforming care of the neediest populations.

We achieve our vision by delivering our mission.

We deliver our mission when we execute on our core model.



How to pay for care

Fee for service

If you need more $$....
RUN FASTER

More procedures = more $$

Value-Based – e.g. Medicare Advantage

If you need more $$...
THINK MORE AND REDUCE HOSPITAL ADMISSIONS

Patients do well = more $$

The PCP of the Future

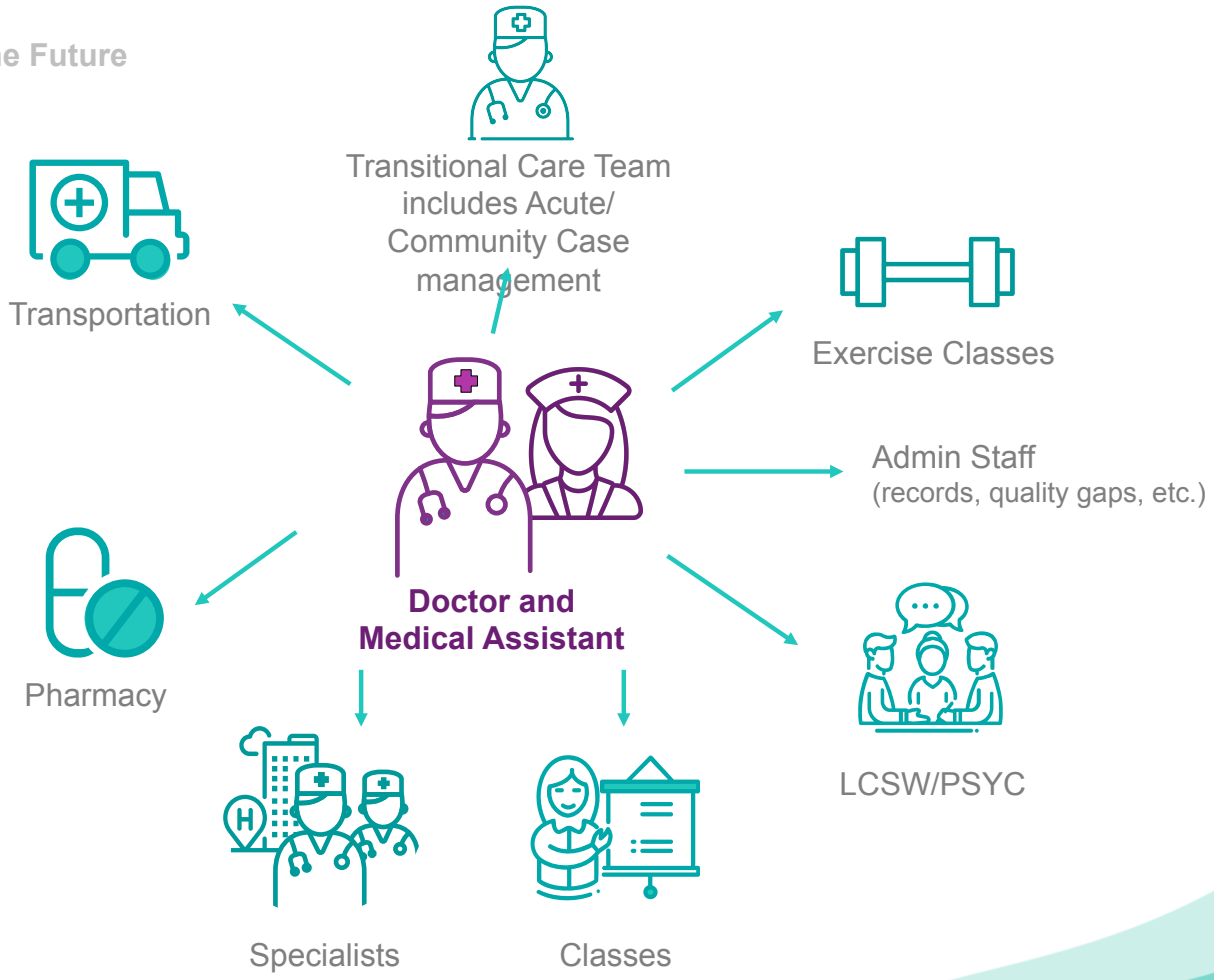
What skills are needed for Value-Based Care? . . .ACS

- **Accountability for Outcomes**
  vs detachment from results
- **Coaching for Health**
  vs consulting for sickness
- **Simplify for action**
  vs add more complexity

The Care Team of the Future

The Care Team of the Future

- 450 patients
- Monthly visits
- 10x more face time/yr.



ChenMed's Impact

Outcomes and Cost

High Touch Care = Better Outcomes

Patient affordability

Better patient health

Physician leadership

Health Plan quality, margins, and growth

OVER 30% FEWER hospitalizations

33% FEWER ER visits

28% LOWER cost

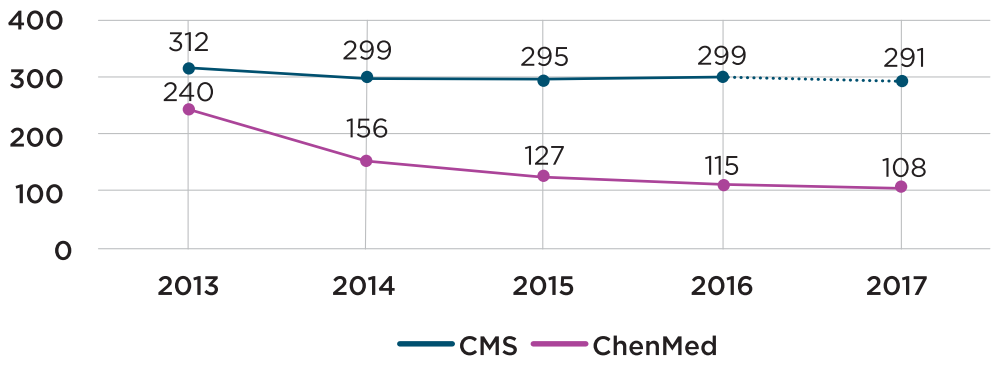
41% INCREASE in preventative medication use

TOP DECILE patient satisfaction score

TOP DECILE clinical quality metrics

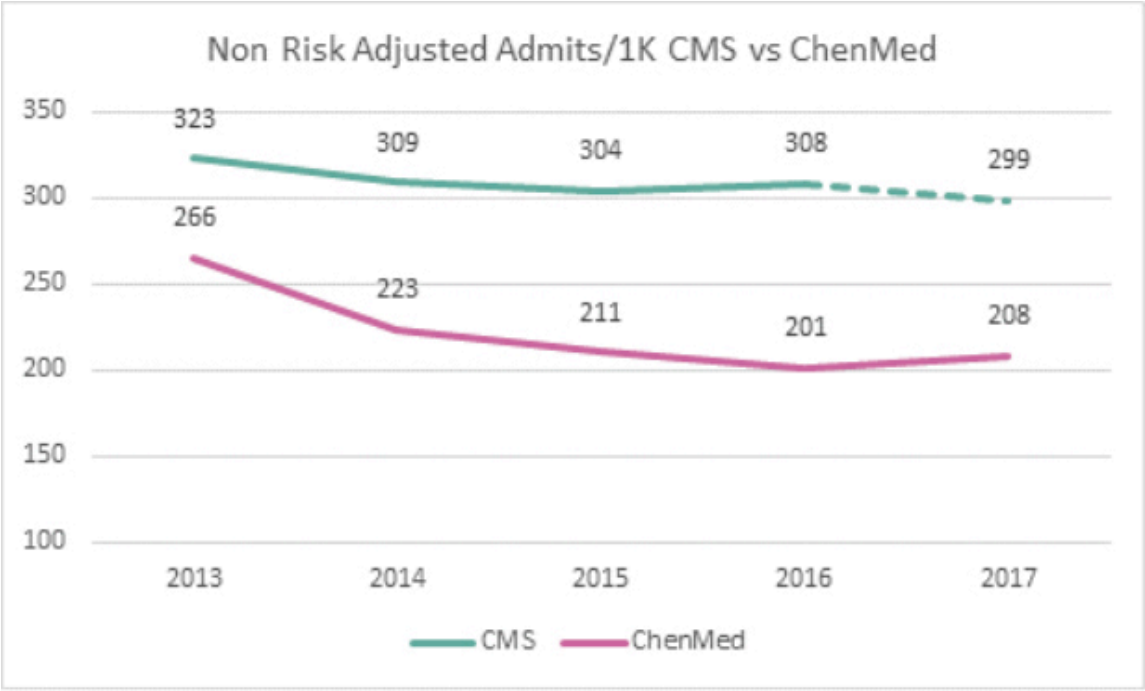
5 Years Better Health
Admissions

INPATIENT HOSPITAL ADMISSIONS**



2017 ChenMed average shatters CMS' trend line by 184 inpatient hospital admissions per 1,000 patients.**

** Comparison with most recent average (when compiled 2018) per thousand measures for the 14 Counties where ChenMed served seniors (2016), as reported by the US Centers for Medicare and Medicaid Services, 2016. ChenMed's outperformance of CMS averages for ER Visits, Hospital Admissions and Bed Days / 1K reported by CMS and ChenMed are normalized for patient acuity.



** Comparison with most recent average (when compiled 2018) per thousand measures for the 14 Counties where ChenMed served seniors (2016), as reported by the US Centers for Medicare and Medicaid Services, 2016. ChenMed's outperformance of CMS averages for ER Visits, Hospital Admissions and Bed Days / 1K reported by CMS and ChenMed are unadjusted for acuity

reimagine

the way you

PRACTICE

medicine

Faisel Syed, MD
National Director Primary Care, ChenMed
faisels@chenmed.com
http://www.chenmed.com/physicians