



Payment Matters: The ROI for High-Intensity Primary Care Payment

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What is High-Intensity Primary Care?

High-intensity primary care provides patient-centered, team-based care to those patients with the most significant health care needs (e.g., multiple chronic conditions). The patient's team of medical professionals (which may include a primary care physician, specialists, a behavioral health clinician, a nurse care manager, a health educator, and a community health worker) work together with the patient to support him or her in developing and following his or her individualized care plan. This model of care often includes a significant level of patient-provider interaction (potentially daily) using in-person visits, telephone calls, and email.

High-Intensity Primary Care Payment: Good Return on Investment for Employers

As the largest purchaser of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are switching from the inefficient fee-for-service model of paying for care, which encourages high volume and low quality, to payment models that reward high value.

For example, there is emerging evidence that high-intensity primary care payment programs are yielding a good return on investment for employers. In this brief, we highlight the early successes of three organizations—the Boeing Company, a union in Atlantic City, and the California Public Employees' Retirement System—with implementing high-intensity primary care payment programs. In addition, many other organizations have been impressed with the promise of high-intensity primary care programs and have begun to support the model, including the Centers for Medicare and Medicaid Services.¹

Case Study #1: Boeing's Success Story—Health Improved while Per Capita Spending Dropped

In 2008, Boeing launched a pilot initiative called the Intensive Outpatient Care Program (IOCP) to use high-intensity primary care to support 740 Boeing employees, pre-Medicare retirees, and adult spouses with severe chronic illnesses. Boeing engaged three Seattle-area physician groups that were willing to offer high-intensity primary care services in exchange for receiving set monthly payments for each patient enrolled. Each patient was assigned to a care team that included a registered nurse care manager and at least one IOCP-dedicated physician. The care team worked with each patient to develop an individualized plan of care and supported the patient through rapid access to care and frequent communication with the patient (in-person visits, telephone calls and emails). The pilot's results were impressive. Not only did per capita spending drop 20 percent relative to a control group, patients' functional status scores, depression scores, experience of

care scores, and employees' absenteeism scores *all* improved after enrollment in the program. The drop in spending was primarily due to a reduction in emergency department visits and inpatient hospital stays. These reductions more than offset the additional fees paid to the physicians and any increases in office visits, pharmacy, and lab services.² Since the pilot ended in 2009, Boeing has expanded the program to include additional sites.

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Case Study #2: Union Slows Spending and Improves Health of Hotel Workers

In 2007, Local 54 of the Hotel Employees and Restaurant Employees International Union Welfare Fund identified a primary care practice known as the "Special Care Center" to provide individualized, team-based care to its most costly and medically complex members. Since implementation, the total costs of the program have fluctuated, but preliminary data suggest that after the first year in existence, the center generated net savings for enrolled patients. A 2009 case-control study of 447 patients showed that total net spending was 12.3 percent lower (\$208 per enrollee per month less) than the control group. Additionally, the program helped enrollees manage their blood sugar levels and blood pressure, lower their cholesterol (an average decline of 30 points) and increase healthy behaviors related to smoking cessation and medication compliance.³

Case Study #3: California Public Employees' Retirement System's (CalPERS) Program Shows Early Results

In June 2011, CalPERS implemented the "Priority Care" program to deliver high-intensity primary care services to members with chronic health care needs receiving care from the Humboldt-Del Norte IPA. After identifying those members most likely to benefit from this additional health support, CalPERS engaged 125 members in the program. The project will be formally evaluated for ROI in 2013, but the state reports encouraging preliminary

How You Can Implement a High-Intensity Primary Care Program

1. Speak with your plan administrator about his or her experience with such programs. There are growing numbers of applications based on the positive results described in this brief.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group and/or health system that serves your population and ask about their experience with high-intensity primary care, and their willingness to apply their program or develop a new one to serve your employees.
3. Read more about high-intensity primary care programs on the Robert Wood Johnson Foundation's website. <http://www.rwjf.org/en/about-rwjf/newsroom/features-and-articles/Brenner11.html>
4. Get suggestions for implementing high-intensity primary care programs by reading this Robert Wood Johnson Foundation brief on "Hot Spotting." <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/01/expanding-hot-spotting-to-new-communities.html>
5. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. <http://forces4quality.org/a/6/payment-reform#featured-resource>

findings. One patient case example is compelling: a program participant went from spending an average of \$2,947 per month prior to enrollment to an average of \$640 per month during the first four months after enrollment.⁴

Endnotes

1. Centers for Medicare and Medicaid Services. Health Care Innovation Awards: New Jersey. <http://innovation.cms.gov/initiatives/health-care-innovation-awards/new-jersey.html> (accessed February 12, 2013).
2. Milstein, A., Kothari, P. Are Higher-Value Care Models Replicable? Health Affairs Blog. October 2009. <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-> (accessed December 12, 2012).
3. Primary Care Physician and Health Coach Teams Improve Outcomes and Reduce Costs for Complex Patients. AHRQ Health Care Innovations Exchange. Agency for Health Care Research and Quality. <http://www.innovations.ahrq.gov/content.aspx?id=2941> (accessed December 12, 2012).
4. Telephone interview with Ann Boynton and email correspondence with Dr. Kathy Donneson, California Public Employees' Retirement System on December 11, 2012 and December 12, 2012, respectively.