UNC Health Systems and Blue Cross and Blue Shield of North Carolina Patient-Centered Medical Home Collaborative

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UNC Health Systems and Blue Cross and Blue Shield of North Carolina have entered into a joint venture that is designed to improve patient outcomes and experience and to control medical costs for patients with chronic conditions. This commentary reviews the impetus for, and the anticipated outcomes of, the model practice.

UNC Health Systems and Blue Cross and Blue Shield of North Carolina (BCBSNC) announced a new model primary care joint venture in January 2011, with the promise of innovations in health care delivery, improved patient experience and health outcomes, and lower overall costs for patients with chronic medical conditions. The model practice, which is based on the patient-centered medical home (PCMH) concept, will offer care for up to 5,000 BCBSNC members in the area of Durham and Orange counties, with a particular focus on patients with multiple chronic conditions, including diabetes, hypertension, cardiovascular disease, asthma, hyperlipidemia, and obesity.

The impetus for this new approach is 3-fold. First is the recognition by UNC Health Systems and BCBSNC that the current primary care models are neither as effective as they need to be nor financially sustainable. At the same time, the health care reform legislation assumes that primary care—and, in particular, PCMHs and accountable care organizations (ACOs)—will improve the results and efficiency of the US health care system. The key disconnect is that the current primary care workforce is aging, and medical students (with their average educational debt of $150,000 and their desire for a reasonable work-life balance) are avoiding primary care like the plague. Even with the infusion of new osteopathic and allopathic medical schools, as well as midlevel practitioner programs, it is unlikely that graduating students will choose primary care unless the prospects for clinical and economic success improve.

The second rationale for establishing a model primary care practice is that pilot studies performed by BCBSNC and others have demonstrated that PCMHs are effective at improving key health care results (eg, hemoglobin A_{1c} levels in patients with diabetes) and reducing overall medical costs. That said, PCMH models are highly variable in their care processes, technologies, and resources, and it is not clear which of these drives the improved results of PCMHs. The model practice, which will serve only BCBSNC members, will have access to robust clinical and payer data regarding the treatment, cost, and outcomes for the practice population and will allow for controlled evaluations of newly introduced interventions, communication methods, patient incentives, primary care practitioner reimbursement, and technologies. Those that work will be retained; those that do not work can be discarded or revised.

Finally, the model practice introduces a dramatically different relationship between provider and payer. The parties will equally contribute to the operating costs and the administrative costs of the practice and will establish quality-of-care and patient-satisfaction targets. It behooves the payer to reduce the administrative burden on the practice, and it will be important for the practice to pay attention to quality and cost metrics for services provided to members across the full spectrum of the health care system. For the pilot to be successful, the level of trust and transparency for operations, finances, patient experience, and health outcomes will need to far exceed that for typical contractual relationships.

The practice, which is scheduled to open in December 2011, will offer typical primary care services, including physician and midlevel practitioner visits and laboratory testing, but will explore alternative methods to delivering those services. Group visits, televisits, e-visits, and Web-based home monitoring are among a number of ways primary care providers will interact with patients. In addition, the practice will offer on-site nutritional counseling, behavioral health services, pharmacy services, and a health coach/case manager. The focus will be on the patient's health and all that contributes to it, rather than on illness events.

Patients will have access to an online patient portal that will allow them to make appointments and view laboratory,

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diagnostic study, and consultation results, as well as to view critical health information. Before a visit, patients will be asked to provide secure online information regarding symptoms, medication adherence or issues, key self-monitored data, and current questions or symptoms, so that the practice health care team can review it before the visit and prepare for a more productive encounter.

Providers, besides having patient-entered information, a claims-based clinical history, and the electronic medical record at their disposal, will also have an imbedded decision-support system to guide them in developing a care plan with the patient. The electronic medical record will help integrate care within the UNC Health Systems, and the addition of payer claims–based information will provide a window into care delivered outside the health system. Perhaps as important, some of the necessary (under the current health care reimbursement paradigm) but burdensome and administratively costly health-plan medical-management requirements will be automated, reduced, or eliminated.

While the concept is not unique on the surface, practitioners in the practice will be salaried, with incentives based on improvements in patients' health results and patients' experiences. In other words, the practitioner will be incentivized only on the quality of outcomes and patient satisfaction, not on the volume of patients seen. The parent organizations will track services provided, with cash flow being managed as a fee-for-service reimbursement, but the ultimate financial success for the practice will be based on the total cost of the patient population's care, compared with that of a comparable group of patients. What will be unique is the joint capability to model financial outcomes under alternative reimbursement models (eg, management fees, capitation, health benefit plans, and patient incentives). By use of predictive models, the practice can also model anticipated behavior changes of patients and providers under various financial systems.

The model practice will need to be operational for at least 3 years for an evaluation of its impact to be conducted, and even longer as interventions and technologies are added and evaluated. Both UNC Health Systems and BCBSNC have committed to maintaining the pilot for at least that long, recognizing that, although care within the practice may be more costly, the overall cost should be lower as care is better integrated and redundancy, inefficiency, and waste are reduced.

Ultimately, both organizations intend to replicate the successful portions of the pilot and avoid activities or processes that do not provide value to patients, providers, and/or payers. The final lesson learned will be whether 2 large organizations with well-meaning but disparate cultures and perspectives can launch and oversee an effective and sustainable patient-focused primary care practice that may well serve as the nidus for the elusive and yet-to-be-defined ACO and for health system reform.

Stay tuned. Learn with us. And remember, it's all about the patient! NCMJ

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