



ONLINE CARE

*A Practical Solution for Enabling
the Medical Home*





Executive Summary

The healthcare system's struggle to coordinate the care of an increasingly ill population has united many in the industry around the vision of a Patient-Centered Medical Home (hereafter: medical home). In this model, physicians are empowered to shift from episodic treatment – or “sick care” – to consistent management of a patient's overall health needs. Early data confirms the medical home's potential to help health plans increase care quality while reducing cost. But adoption requires solutions that can deliver results upon launch, while complementing existing programs, systems, and processes.

Health plans looking to make the medical home a reality for their members are increasingly turning to Online Care (see sidebar, “What Is Online Care?”). Online Care allows immediate access to care and empowers primary care physicians (PCPs) with information and tools. But Online Care also enables a series of “firsts” for health plans introducing medical homes:

- *The ability to broker a team of multi-disciplinary physicians in service of an individual patient, all with the supervision of a PCP;*
- *The removal of administrative burden from patients' shoulders when they assemble and engage the right physician team for them;*
- *The creation of a single audit trail and exchange of consistent clinical information with the patient and among members of the care team;*
- *The integration of medical home biometrics directly into the care encounter;*
- *The ability of the entire medical team, whenever needed, to literally come into the patient's home and deliver care collaboratively.*

This evaluation of Online Care's role in the medical home will:

- Examine the promise of the medical home;
- Describe the key success factors and challenges for health plans deploying the medical home for their members;
- Explain the role of Online Care in accelerating medical home introduction, while overcoming challenges.

What Is Online Care?

Online Care offers consumers the ability to come together with physicians online and receive immediate healthcare services. In the past, consumers relied on Web-based technologies such as portals to obtain and manage information about their health. With Online Care, they receive actual healthcare services from physicians, without scheduling an appointment or leaving their homes.

When a health plan offers Online Care, physicians in its existing network can make themselves available for online and phone consultations at any time, from any location, and for as long as they choose. An Online Care system pools these physicians according to specialty and brokers their interactions. As a result, consumers seeking care can log into their health plan's Web site, then find and immediately connect with the physician who is right for their needs.

During the Online Care visit itself, consumers can see and talk to their physician while sharing notes on screen. The physician can answer questions and, if necessary, write prescriptions or refer the consumer to another physician for a specific concern or second opinion.

Background: The Introduction of the Patient-Centered Medical Home

When the visit concludes, the co-pay is charged to the consumer's credit card, and a claim is processed automatically through the health plan. The consumer can share a record of the conversation with his or her primary care physician, ensuring the continuity of care. All records are stored for reference at any time – and consumers retain control over that information. The experience resembles online services that have been well-established for years, from buying a book on Amazon.com to planning travel on Expedia.

The numbers show strong consumer demand for Online Care. In a recent survey conducted by market research leader TNS Global with American Well, more than 70 percent of consumers said they will use Online Care when offered the option. The ability to access physicians instantly drives that demand, with nearly half of consumers saying they'd use Online Care to speak with a physician before heading to the ER or scheduling an office visit. Fifty-five percent would use it to get a medical question answered immediately. Ultimately, these consumers hope to spend less time finding the right doctor, scheduling an appointment, or taking time off of work.

The US healthcare system is under increasing strain. Health plan executives understand the situation all too well: Americans' health needs are becoming more intense and complex, fueled by a growing burden of chronic illness and an aging population. Making matters worse, chronic illnesses and their related conditions require a level of cohesive, coordinated care that the healthcare system struggles to deliver. As a result, many Americans turn to specialists for whole-person treatment or assume the role of care manager themselves – with negative impacts on outcomes and at a high cost.

- **The need for care coordination is increasing...** By 2023, the Milken Institute projects a 42 percent increase in prevalence of seven common chronic diseases.¹ This unfortunate trend is already well underway, with the number of diabetes sufferers increasing by more than 3 million between 2005 and 2007.² In parallel, innovation in new treatments, medications, and procedures to manage these and other illnesses require further specialization of care givers.
- **... causing the healthcare system to fray.** In 2005, the Commonwealth Fund included the US in a comparative study of six nations, concluding: “overall, the United States stood out for high error rates, inefficient coordination of care, and high out-of-pocket costs resulting in foregone care.”³ A variety of issues accompany this performance, including the shift of providers from general to specialist care and the growth of consumer-driven healthcare.
- **Patient outcomes suffer.** A 2007 California Healthcare Foundation study found that 40% of physicians reported that patients experienced problems because care was not well-coordinated among providers and sites.⁴ Further, a Harris Interactive survey found that 14% of patients with chronic conditions received different diagnoses from different providers, while 17% received conflicting information from physicians.⁵

In response, providers are advocating the return of a strong partnership and dialogue between patients and their physicians – in the form of the Patient-Centered Medical Home. First introduced in the context of pediatrics in 1967, the medical home gained momentum in March of 2007, thanks to a joint statement of the American Academy of Pediatrics (AAP), American Academy of Family Practitioners (AAFP), American College of Physicians (ACP), and American Osteopathic Association (AOA).⁶ These organizations describe the characteristics of the medical home with the following principles:

- **Personal physician.** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care;



- **Physician-directed medical practice**, meaning the personal physician leads a team of individuals at practice level who take collective responsibility for ongoing patient care;
- **Whole person orientation**, with the personal physician responsible for providing all patient health care needs or appropriately arranging care with other qualified professionals. Care spans all life stages including acute, chronic, preventive, and end-of-life care;
- **Coordinated and/or integrated care** across all elements of the complex healthcare system and the patient's community;
- **Quality and safety**, including guiding decision-making with evidence-based medicine and aided by clinical decision-support tools;
- **Accessibility**, through systems such as open scheduling, expanded hours, and new options of communications between patients, their personal physician, and practice staff;
- **Payment** that appropriately recognizes the value physicians provide to patients who have a patient-centered medical home.

Primary Care: Front and Center in the Medical Home

While the medical home joint statement identifies many principles for coordinating care effectively, the primary care physician (PCP) plays a central role throughout. With good reason: not only are PCPs uniquely positioned and skilled to fill these shoes, their orchestration of a team of care providers can improve patient outcomes at a lower cost. One study found that adults who rely on a PCP rather than a specialist as their personal physician experienced 19% lower adjusted mortality and 33% lower annual cost of adjusted care.⁷ Because PCPs draw together a team of care providers and maintain a complete view of a patient's health, their involvement is associated with increases in appropriate preventive care.⁸

As a result, the medical home has the potential to magnify these benefits, improving both the economics and the

outcomes of healthcare delivery. The Commonwealth Fund estimated last year that Medicare would save \$194 billion over 10 years if it created medical homes for all of its fee-for-service patients.⁹

Health Plans Step Up, But Challenges Slow Adoption

Realizing a vision as ambitious as the medical home requires the cooperation of stakeholders across the healthcare system: providers, payers and patients. With that in mind, health plan executives throughout the US have taken advantage of their role bridging these groups, launching a series of medical home initiatives and pilots. According to the Healthcare Intelligence Network, more than half of respondents in a recent survey said they were currently trying to set up medical homes, with another 20 percent intending to follow suit in the next 12 months.¹⁰ Some initiatives already show encouraging signs of success, from two-year Medicaid savings exceeding \$230 million in North Carolina to increased treatment protocol compliance in New Jersey and reduced hospital admissions in Pennsylvania.

Despite these early wins, overall roll out of the medical home remains modest. According to Healthcare Information Network, nearly one-third of respondents in a recent survey say that fewer than five percent of their members/patients have a designated medical home. Another 30 percent aren't sure.¹¹

Part of the challenge for health plans is deciding **where and how to start**. The medical home has many dimensions, so an initiative could include efforts as diverse as extending office hours; rolling out decision-support tools; offering new services; creating new reimbursement and incentive models; mandating new documentation and reporting standards – or some combination of the above. The choice is a daunting one. As with any complex initiative, executives are expected to prove the value of medical home initiatives with early and substantial results.

One of the largest initial barriers to success of any new clinical program, the medical home included, is making sure efforts **complement existing programs, systems,**

and processes. These include payer-based systems such as claims submission, provider credentialing, and revenue cycle management. Workflows including documentation, medical records, scheduling/staffing, and quality monitoring cannot be disrupted. For long-term success, the ability to **reduce cost** must be proven.

A **shortage of primary care providers** in many areas creates another headwind to medical home introduction. While the number of overall physicians grows, PCPs are in steady decline. The percentage of US medical school students selecting a residency in primary care specialties is shrinking – from 53% in 1998 to just 15% in 2006 – all while practicing physicians transition out.¹² Only 20% of internal medicine residents choose to go into primary care, down from half in 1998.¹³ A 2008 Health Affairs article projects, “By 2025, the nation will be short 35,000 to 44,000 adult care generalists practicing family medicine and general internal medicine.”¹⁴

Health plans that want to extend the benefits of the medical home to their physicians and members must not only fulfill the vision and requirements of the joint statement. They need a solution that:

- *Has an impact out of the gate;*
- *Complements existing health plan programs, systems and processes already in place;*
- *Realizes the promise of cost efficiency;*
- *Maximizes scarce primary care capacity and physician productivity.*

Online Care and the Medical Home

During the past year, health plan executives committed to making the medical home a reality gained an important new tool: Online Care. Online Care enables consumers to come together with physicians online and receive immediate healthcare services, using the latest Web-

based technologies (see Figure 1, “Online Care Provides Immediate Physician Access”). It advances medical home efforts on two fronts:



Figure 1, “Online Care Provides Immediate Physician Access”

- **Online Care delivers the vision of the medical home.** Not only does Online Care fulfill the requirements for more convenient, accessible, and immediate care, it specifically empowers both patients and PCPs. For the first time, patients can access and assemble the multi-disciplinary team of physicians that is right for them, with instant transparency into eligibility and payment. Physicians gain new information and tools that help them manage the health of the whole person – at the exact moment of treatment. In addition, Online Care provides the infrastructure and processes for an entire multi-disciplinary team of care providers to collaborate in a cohesive, centralized manner. Finally, Online Care brings the medical home ... to the home. Patients can access treatment in the comfort and safety of their living rooms, whenever it is needed.
- **Online Care overcomes key challenges that can befall other medical home efforts.** Online Care stands out among initiatives that support the medical home in that it can provide immediate benefits to a health plan’s entire physician network and member population upon launch. The processes at the core of Online Care – from finding a physician to receiving



MEDICAL HOME PRINCIPLE	ONLINE CARE'S IMPACT
1 ONGOING PERSONAL PHYSICIAN	<ul style="list-style-type: none"> Easier to choose the right physician Supports continuous, comprehensive care
2 PHYSICIAN-DIRECTED PRACTICE	<ul style="list-style-type: none"> PCP-centered system Reinforces treatment plans
3 WHOLE PERSON ORIENTATION	<ul style="list-style-type: none"> Single point of visibility into patient Care teams literally come into the home
4 COORDINATED CARE	<ul style="list-style-type: none"> Closes gaps among multi-disciplinary providers Helps patients engage and coordinate care teams
5 QUALITY AND SAFETY	<ul style="list-style-type: none"> Physicians have better tools, info at point of care Home is safest setting
6 ACCESSIBILITY	<ul style="list-style-type: none"> Immediate access, any physician, whenever needed Web or phone options
7 PAYMENT RECOGNIZES VALUE	<ul style="list-style-type: none"> Physicians compensated for all time spent on patient Care coordination is part of encounter, compensated

Figure 2, “Online Care Supports Medical Home Principles”

treatment, engaging a team of providers, and processing payment – are already fully integrated into the existing health insurance system. Finally, Online Care actually expands the capacity of care providers. It is also unique among medical home initiatives in improving access for populations that might otherwise be the last to benefit from a medical home, including rural, underserved, and uninsured patients.

Of course, Online Care is not the only care members require as part of their medical home. Sometimes, there is no substitute for seeing a doctor in person. But Online Care does provide much-needed infrastructure and processes for managing all aspects of the medical home, wherever they take place – while also providing an important setting for care delivery.

Delivering the Vision of the Medical Home

How exactly does Online Care enable the medical home? In order to evaluate this question in detail, it makes sense to return to the seven characteristics of the joint statement and consider the role of Online Care in realizing each one (see Figure 2, “Online Care Supports Medical Home Principles”).

- 1) **An ongoing personal physician trained to provide first contact, continuous, comprehensive care.** Online Care supports the role of the ongoing personal physician in three ways. First, if a patient does not already have a personal physician, Online Care makes it easy for them to find and choose the right one for their needs. Patients can make this choice by searching and viewing physician profiles that feature extensive detail about expertise and credentials, as well as the experiences of other patients. Second,

Online Care makes it easier for personal physicians to remain in continuous contact with their patients. Online Care visits replace the need for the headaches and delays of constant office trips, whether the reason is routine follow-up, review of clinical events (e.g., symptom changes or biometric results), or the need for new diagnoses. Finally, personal physicians can expect Online Care to support comprehensive care with a complete view of patients' clinical information, representing all input by the multi-disciplinary care team. This view is available during every consultation. It can include the patient's personal health history, as well as all prior physician interactions and next steps (see Figure 3, "Online Care Provides A Complete View of Patient Information").

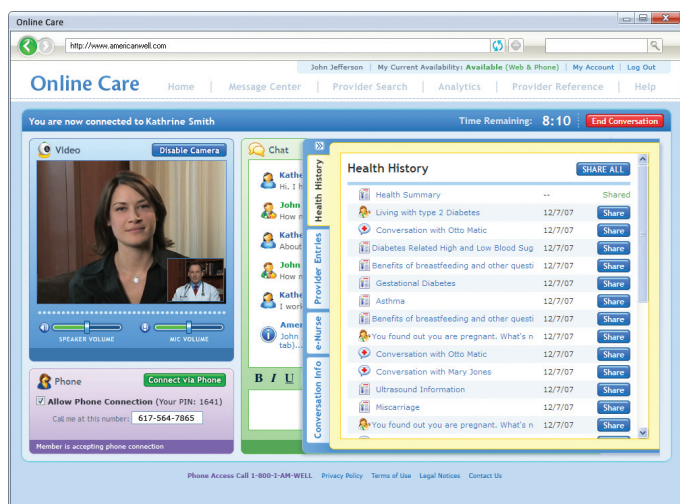


Figure 3, "Online Care Provides A Complete View of Patient Information"

3) Whole person orientation, including acute, chronic, preventive, and end-of-life services. Online Care encourages whole person orientation by offering a single point of visibility into all facets of the patient, including their personal health history, biometric data, and physician interactions. This orientation is enhanced by the fact that physicians providing Online Care literally come into the homes of their patients, where those patients feel most comfortable and secure. Physicians can also use the system to connect to a variety of multi-disciplinary providers in real time, so that all the relevant stakeholders in an individual's health come together and represent every angle.

In terms of services scope, Online Care is particularly well-suited for care delivery that benefits from the home setting. This may include chronic, preventive, and end-of-life care, when mobility may be a concern. It also encompasses patients who live at a distance or have busy lifestyles, and might otherwise delay or defer needed care.

4) Coordinated and/or integrated care. Online Care enables an unprecedented level of care coordination, especially across multi-disciplinary providers where many gaps occur today. As mentioned earlier, one way it does this is by capturing health and treatment history in a single place, then making it available at the point of care. Thus all physicians involved in a patient's care have access to the same level of clinical insight, improving coordination. Furthermore, PCPs can be immediately notified when their patients conduct an online visit and review a full report of the results – so they are always in the loop and can immediately react if they wish.

Online Care takes coordination to a new level by allowing physicians to assemble a team of care providers, in real time, to collaborate on a patient's behalf. This eliminates communication gaps; keeps the personal physician at the center of patient care; compresses a process that otherwise takes weeks or months; and potentially results in better outcomes for the patient. Importantly, Online Care achieves

2) Physician-directed medical practice. Online Care reinforces the place of physicians at the center of patient care. Health plans may choose to offer the services of many types of providers via Online Care. However, patients are strongly encouraged to share records of every discussion with their PCPs, as well as with all other providers they consult with in the future. In addition, patients can show their personal and care histories to these other providers, ensuring that physician-directed treatment plans are understood and reinforced.



this without adding any overhead for the physicians involved or time spent in phone tag, e-mail exchanges, or tracking schedules.

But patients, too, have an important role that is facilitated with Online Care. First, Online Care allows patients to build and integrate the multi-disciplinary team of physicians that is right for them more quickly and easily. Because all participating physicians are already part of their plan, eligibility and payment terms are instantly established. Second, the Online Care system helps ensure patients effectively coordinate across their team of physicians. For example, it can alert patients when their health information or treatment plan indicates the need for an appointment with a specialist – with the alert containing a link to begin the consultation immediately. It even goes a step further by furnishing patients with a specific agenda of topics to discuss with their physicians (see Figure 4, “A Patient’s Online Care Agenda”).

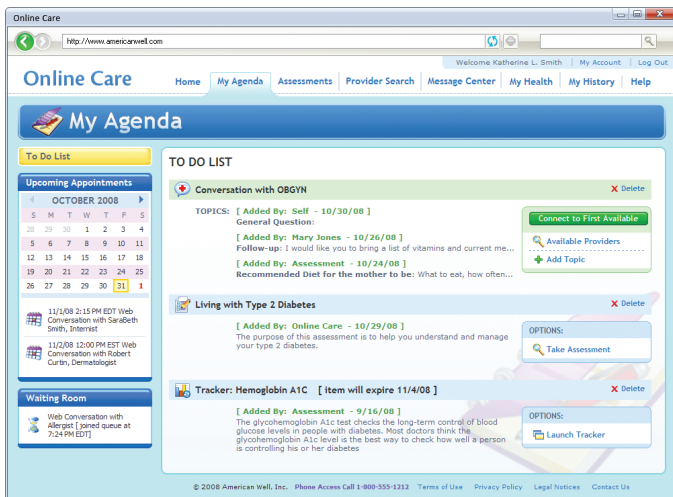


Figure 4, “A Patient’s Online Care Agenda”

5) Focus on quality and safety, including adhering to evidence-based medicine and aided by decision-support tools. Online Care supports quality and safety in several ways. For physicians, the improvements in information availability allow them to focus entirely on treatment, without shuffling through disparate records and data – or, worse, treating without it. Decision-support tools embedded in the workflow

provide further guidance at the point of care, when it is most valuable. The Online Care system offers both treatment suggestions generated by patient health assessments and patient-specific clinical alerts that uncover gaps in care. These alerts are based on medical best practices from the latest evidence-based literature. Finally, the ability for multi-disciplinary teams of providers to meet with a patient in real-time increases the likelihood of a comprehensive treatment plan, while minimizing the chance of dropped balls that occur when care is fragmented.

For patients, Online Care allows them to receive care at home, the safest of all environments. Quality is further helped by the integration of personal health records (PHRs) into treatment during Online Care visits. Because the PHR gains a new level of usefulness, it increases the likelihood that patients will see value in documenting and updating their health histories. Regarding evidence-based medicine, health plans may use Online Care to present medical guidelines, based on current best evidence, precisely when physicians make diagnoses and design treatment plans.

- 6) Accessibility, in part leveraging open scheduling, expanded hours, and new options of communications.** By providing immediate access to care, at any hour it is needed, Online Care overcomes traditional scheduling challenges and delays that occur in office or hospital environments. It also opens several communications channels between patients and their physicians – two-way videoconference, secure text chat, and asynchronous messaging – while fully integrating with telephone communication.
- 7) Payment appropriately recognizes the value physicians provide to patients with a medical home.** In Online Care, physicians can be compensated for all of the time they deliver value to patients. Patient visits are charged in 10 minute increments; while physicians and patients can decide to extend that window, doing so incurs additional charges. Therefore, both participants are constantly recognizing and committing to the value of further interaction. Online Care also enables payment for care coordination. Coordination can

now happen live and as part of actual care – which is compensated – rather than a siloed administrative task that may be difficult to track or charge for.

Online Care Overcomes Key Medical Home Challenges

Online Care can help health plans to realize the core vision and principles of the medical home. But, practically speaking, it is also straightforward to launch, implement, and grow over time. In this respect, Online Care avoids the challenges that have faced some other medical home initiatives because it:

- **Has an impact out of the gate.** Unlike some other medical home efforts, Online Care allows health plans to ramp up from strategy development to full service availability in a matter of months, across their entire physician and patient networks. Benefits of the medical home are realized on day one, including improved access, empowered physicians and better care coordination.
- **Complements existing health plan programs, systems, and processes.** Online Care does not exist in a silo with its own rules or business practices. It is fully designed to complement and extend the processes already in place at health plans – from physician credentialing to patient interaction, claims processing, and payment. Further, the system can draw information and services from other programs, including PHRs, analytics engines, and disease management applications. This simplifies the process of introducing the medical home and frees health plans to focus on providing a quality new service for their members.
- **Realizes the promise of cost efficiencies.** The potential of Online Care to bring efficiency to the healthcare system – one of the necessary outcomes of the medical home – is measured and documented. By shifting more care to the home setting, Online Care is expected to impact utilization of health care services in a very positive way. The actuarial firm Milliman estimates that the provision of Online Care by health plans has the potential to provide first-dollar medical savings of

\$3.36 and \$6.95 per-member-per-month (PMPM) for commercial and Medicare plans, respectively. Savings largely come from the substitution of non-emergent ER visits and in-person visits (both acute and follow-up) with lower cost Online Care interactions.

- **Maximizes scarce primary care capacity and physician productivity.** In light of the current PCP shortage, Online Care has the potential to increase capacity in support of the medical home. Because Online Care offers the freedom for physicians to practice whenever they want and wherever they want – without overhead – health plans can increase the total PCP labor pool. Retired physicians have the opportunity to re-enter the medical field on terms they choose, while young physicians can ramp up their panels sooner. For established physicians, Online Care allows them to spend otherwise unproductive time seeing patients and earning revenue – for example, evenings while they are already on call for their practices.

Finally, Online Care helps balance capacity within states. Rural patients can immediately see physicians who may be based in big cities, who are otherwise a long drive or flight away. If a health plan chooses to offer Online Care to all residents of a state, the uninsured or underinsured can also have access to it. Many of these populations might otherwise be the last to benefit from a medical home.

Conclusion

When the AAFP, AAP, ACP, and AOA issued their joint principles on the Patient-Centered Medical Home, it was because changes in the US population and shape of the healthcare industry required a dramatic new vision to re-center care. Health plans have embraced the vision, but practical solutions to achieve it have been challenging to find. Executives understand that such a fundamental change can have no single “silver bullet.”

However, the advent of Online Care provides an opportunity for health plans to make swift, comprehensive progress toward realizing the promise of the medical



home on several critical fronts. These range from improving accessibility to empowering personal physicians to make better informed, coordinated decisions on behalf of patients. At the same time, Online Care incorporates the latest technology to bring entirely new capabilities to the table, including brokering a team of multi-disciplinary physicians under the PCPs supervision; removing administrative burden from the shoulders of patients; centralizing clinical information; and enabling the entire care team to literally enter the patient's home.

Importantly, health plans can introduce Online Care in a focused manner that complements the business processes that already work. This ensures the emphasis remains where it belongs: strengthening the physician-patient relationship and improving outcomes for all stakeholders in the healthcare system.

— Endnotes —

- 1) Ross DeVol and Armen Bedroussian, with Anita Charuworn, Anusuya Chatterjee, In Kyu Kim, Soojung Kim and Kevin Klowden, "An Unhealthy America: The Economic Burden of Chronic Disease – Charting a New Course to Save Lives and Increase Productivity and Economic Growth." Milken Institute, October 2007.
- 2) "Number of People With Diabetes Increases to 24 Million." CDC press release, June 24, 2008.
- 3) Cathy Schoen, M.S., Robin Osborn, M.B.A., Phuong Trang Huynh, Ph.D., Michelle Doty, Ph.D., Kinga Zapert, Ph.D., Jordon Peugh, M.A., Karen Davis, Ph.D., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries." The Commonwealth Fund, November 2005.
- 4) "Uncoordinated Care: A Survey of Physician and Patient Experience." California HealthCare Foundation, September 2007.
- 5) "Survey on Chronic Illness and Caregiving." Harris Interactive, January 2001.
- 6) <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>
- 7) Franks and Fiscella. *Journal of Family Practice*, 1998. 47:103.
- 8) National Health Interview Survey (Breen et al. 2001).
- 9) Alice Dembner, "A More Welcoming Model for Care." *Boston Globe*, May 19, 2008.
- 10) Laura M. Greene, "Medical Homes: Awareness and Early Success." HIN E-Survey of the Month, March 2008.
- 11) Laura M. Greene, "Medical Homes: Awareness and Early Success." HIN E-Survey of the Month, March 2008.
- 12) David D. Howes, MD, "Medical Home: A Comprehensive Approach to Patient Care." AHIP Institute presentation, June 2008.
- 13) Nancy Shute, "Can't Find a Doctor? You're Not Alone." *US News & World Report*, March 19, 2008.
- 14) "The United States Faces a Shortage of Generalist Physicians to Provide Primary Care for Adults," *Health Affairs*, April 29, 2008. As summarized in *Healthcare Daily Data Byte*, May 13, 2008.

