Patient Centered Medical Home

Paul Grundy MD, MPH
IBM‘s Director Healthcare Transformation
President Patient Centered Primary Care Collaborative
Paul Grundy MD MPH Bio

- “Godfather” of the Patient Centered Medical Home
- IBM Global Director Healthcare Transformation
- President of PCPCC
- Member Institute of Medicine
- Member Board ACGME
- Professor Univ. of Utah Department Family Medicine
- Winner NCQA national Quality Award
- A Leader of MOH level taskforce primary care transformation 8 nations: USA, Canada, New Zealand, Australia, Holland, Denmark, UK, Belgium,
- Univ. of California MD, John Hopkins Trained
Course Objectives:

Participants will be able to:

- Define the current landscape of Health Care Reform transformative efforts as it relates to ambulatory care;

- Identify the basic tenets of:
  - Population Management,
  - Patient Centered Medical Home,
  - Accountable Care Organizations,
  - Value Based Purchasing;

- Define care coordination opportunities between primary and specialty care services;

- Verbalize the role of Health Information Technology in the advancement of ambulatory care and improved patient outcomes.

Disclosure:

I am a full time Employee of IBM  I WILL NOT discuss any pharmaceuticals, medical procedures, or devices
The System Integrator

- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management

Away from Episode of Care to Management of Population

System Integrator

- Population Health
- Per Capita Cost
- Patient Experience
- Public Health

Hospital

Community Health

- Safety and Quality
- Whole Person Orientation
- Enhanced Access
- Physician Directed Practice
<table>
<thead>
<tr>
<th>TODAY’S CARE</th>
<th>PCMH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me.</td>
<td>Our patients are the population community.</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today.</td>
<td>Care is determined by a proactive plan to meet patient needs with or without visits.</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor.</td>
<td>Care is standardized according to evidence-based guidelines.</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained.</td>
<td>We measure our quality and make rapid changes to improve it.</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care.</td>
<td>A prepared team of professionals coordinates all patients’ care.</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them.</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital.</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs.</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
36.3%  Drop in hospital days
32.2%  Drop in ER use
12.8%  Increase Chronic Medication use
-15.6%  Total cost
10.5%  Drop Inpatient specialty care costs
18.9%  Ancillary costs down
15.0%  Outpatient specialty down

• 44% reduction in hospital costs

• 21% reduction in overall medical costs.

• 160 PCMH practices Pennsylvania from 2008 to 12

• Number of patients with poorly controlled diabetes declined by 45%.

Jeffrey Bendix modernmedicine.com/>
PCMH Michigan – Aug 11th 2013

• 19.1% lower rate of adult hospitalization.
• 8.8% lower rate of adult ER visits.
• 17.7% lower rate ER visits (children under age 17)
• 7.3% lower rate of adult high-tech radiology usage VS other non-PCMH designated primary care physicians.

3,017 Physicians

Medical home physicians help patients avoid ERs and admissions by evening hour appointments, weekend and same-day appointments

WellPoint PCMH Preliminary Year 2 Highlights  In Sept

Issue Health affairs 2012

- 18% decrease in acute IP admissions/1000, compared to 18% increase in control group
- 15% decrease in total ER visits/1000, compared to 4% increase in control group
- Specialty visits/1000 remained around flat compared to 10% increase in control group
- Overall Return on Investment estimates ranged between 2.5:1 and 4.5:1
• 1/3 less cardiac intervention needed
• 60% less complication Diabetes
Actual client data: Midwest Hospital with 12,135 employees 1 year self-funded for group health

12 month rolling PEPM averages
Trajectory to Value Based Purchasing: Achieving Real Care Coordination and Outcome Measurement

Value-Based Purchasing: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)

Value/Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures

Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement

Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination $

Primary Care Capacity: Patient Centered Medical Home

HIT Infrastructure: EHRs and Connectivity

Source: Hudson Valley Initiative
Defining the Care Centered on Patient

- Superb Access to Care
- Patient Engagement in Care
- Clinical Information Systems, Registry
- Care Coordination
- Team Care
- Communication
- Patient Feedback
- Mobile easy to use and Available Information
My patients are those who make appointments to see me
--> Our patients are those who are registered in our medical home..

Care is determined by today’s problem and time available today  -->
Care is determined by a proactive plan to meet health needs, with or without visits

...  

Care varies by scheduled time and memory or skill of the doctor  -->
Care is standardized according to evidence based guidelines and advance clinical decision support.

...  

I know I deliver high quality care because I’m well trained
--> We measure our quality and make rapid changes to improve it

...  

Patients are responsible for coordinating their own care
--> A prepared team of professionals coordinates all patients’ care

It’s up to the patient to tell us what happened to them
--> We track tests and consultations, and follow-up after ED and hospital

Clinic operations center on meeting the doctor’s needs
--> A connected interdisciplinary team works at the top of our licenses to serve patients
“We do the best heart surgeries.”
Patient Centered Medical Homes (PCMH) within the Federal Employees Health Benefits (FEHB) Program

- A growing body of evidence supports investment in PCMH - SO we are!!
- there must be a plan for all FEHB lives enrolled in the practice to be included in a reasonable timeframe.

- ACA 2334
http://www.amazon.com/Familiar-Physician-Saving-Doctor-Obamacare/dp/1614487375/ref=sr_1_1?s=books&ie=UTF8&qid=1375885302&s=books&ie=UTF8&qid=1375885302&sr=1-1&keywords=The+Familiar+Physician

“Everyone should care very deeply about the plight of their family physician. The most trusted member of most societies, including America’s, is the healer...”

Paul Grundy, MD
IBM’s Global Director of Healthcare Transformation
“Champion of the Medical Home Concept in America”

THE FAMILIAR PHYSICIAN

Saving Your Doctor In the Era of Obamacare

PETER B. ANDERSON, MD
WITH BUD RAMEY AND TOM EMSWILLER
MobileFirst Patient Consumer

New Appointment
Preferred Provider
My Primary Care Team

Appointment Date
10/1/2010

Primary Reason for Office Visit
- Specific Medical Issue(s)
- Specific Medical Issue (brief - 10 minute)
- Preventive Checkup / "Annual" Physical Exam

Issue Detail?
- Allergies / Hayfever
- Cold / Flu / Sinus
- Female with UTI
- Yeast Infection
- None of the Above
Mobile Sensing emotion for mental health status -- analyzes facial expressions
Mobile Sensing position for asthma -- integrates GPS into inhalers
Mobile Sensing motion for Alzheimer’s -- monitoring gait
Mobile Sensing ingestion of medications. activated by stomach fluid

Mobile Sensing for sleep disorders -- tracks breath, heart rate, motion
Mobile Sensing for diabetes. continuous monitoring iPhone non invasive sensor.
Mobile Sensing for readmission prevention -- BP, weight, pulse, ekg
Mobile Sensing for exercise wellness -- benefit design feedback
Practice transformation away from episode of care

**Master Builder**

- Preventive Medicine
- Chronic Disease Monitoring
- Medication Refills
- Acute Care
- Test Results
- Case Manager
- Behavioral Health
- Medical Assistants
- Nursing

Source: Southcentral Foundation, Anchorage AK
PCMH Parallel Team Flow Design

The glue is real data not a doctors Brain

Chronic Disease Monitoring
  - Medication Refills
    - Case Manager

Acute Care
  - Test Results
    - Preventive Medicine
      - Acute Mental Health Complaint
        - Medical Assistants
          - Behavioral Health

Point of Care Testing
  - Compliance Barriers
    - Behavioral Health

Source: Southcentral Foundation, Anchorage AK
Healthcare will Transform

• Data Driven
• Every patient has a plan
• Team based
• Managing a Population Down to the Person
Payment reform requires more than one method, you have dials, adjust them!!!

“fee for health”
fee for value
“fee for outcome”
“fee for process”
“fee for belonging
“fee for service”
“fee for satisfaction”
New $ Dials

- Complex Chronic Care Management payment codes authorize payments to physicians for the work that goes into managing complex patients outside of their actual office visits.
- House Energy and Commerce Committee Bill repeals SGR moving Medicare payments away from FFS toward new, innovative models.
Benefit Redesign - Patient Engagement Different Strategies for Different Healthcare Spend Segments

Those who are well or think they are well

Those with chronic illness

Those with severe, acute illness or injuries

% Total Healthcare Spend

% of Members
Benefit Redesign

- Cost 2013 $16,351 emp on ave paying $4,565
- Federal government Final Rules wellness incentives.
- Smoker --employer may increase your insurance premiums by up to 50 percent.
- Overweight, you may look at a 30 percent surcharge.
- And employers may also reduce premiums by up to 30 percent for normal weight.
benefit design reference pricing

- California Public Employees' Retirement System (CalPERS), from 2008 to 2012.
- Insurer sets limits on the amount to be paid for a procedure, with employees paying any remaining difference.
- Shift by Patients from high to low cost 55.7%
- Hospitals reduced their prices by an ave of 20%.
- Accounted for $2.8 million in savings in 2011

http://content.healthaffairs.org/content/32/8/1392.abstract
Health Aff August 2013 vol. 32no. 8 1392-1397
PCMH 2.0 in Action

Community Care Team
- Nurse Coordinator
- Social Workers
- Dieticians
- Community Health Workers
- Care Coordinators
- Public Health Prevention
- HEALTH WELLNESS

A Coordinated Health System
Health IT Framework
Global Information Framework
Evaluation Framework
Operations

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Blue Plan Care Delivery Innovations

PCMH Level Care in market or in development in 49 states, District of Columbia and Puerto Rico

United HC, Humana, Aetna, CIGNA, Kaiser
Martins Point, CDPHP, Priority,

PCPCC

Note: Information as of October 18, 2012. Program accessibility to National Account members varies by market.
Geisinger’s Proven Health Navigator Model serving Medicare Patients in rural Pennsylvania reported 7.1% savings over expected costs from 2006-2010 with an ROI of 1.7

- **Genesee Health Plan** in Flint, Michigan, reported PCMH services helped reduce ER visits by 51% between 2004 and 2007 and reduced hospital admissions by 15% between 2006 and 2007
- **WellPoint's** PCMH model in New York yielded risk-adjusted total PMPM costs that were 14.5% lower for adults and 8.6% lower for children enrolled in the medical home
- **CareFirst Blue Cross Blue Shield** of Maryland yielded an estimated 15% pmpm savings in the first year and $98 million in savings over two years
- **Group Health of Washington** reported overall cost savings of $17 PMPM including 29% fewer ER visits and 11% reduction in hospitalizations for ambulatory sensitive conditions
- **Oklahoma Medicaid** reported $29 PMPM savings
- **HealthPartners** in Minnesota reported 39% reduction in ER visits, 24% fewer hospitalizations, 40% reduction in readmission rates and 20% reduction in inpatient costs
## Why the Medical Home Works: A Framework

**www.pcpcc.net**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Definition</th>
<th>Sample Strategies</th>
<th>Potential Impacts</th>
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</thead>
</table>
| Patient-Centered               | Supports patients in learning to manage and organize their own care at the level they choose, and ensures that patients and families are fully informed partners in health system transformation at the practice, community, and policy levels. | • Additional staff positions to help patients navigate the system and fulfill care plans (e.g., care coordinators, patient navigators, social workers)  
• Compassionate and culturally sensitive care  
• Strong, trusting relationships with physicians and care team, and open communication about decisions and health status | Patients are more likely to seek the right care, in the right place, and at the right time.  
**Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated** |
| Comprehensive                  | A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. | • Care team focuses on ‘whole person’ and population health  
• Primary care is co-located with oral, vision, OB/GYN, pharmacy and other services  
• Special attention paid to chronic disease and complex patients | **Providers are less likely to order duplicate tests, labs, or procedures**  
Better management of chronic diseases and other illness improves health outcomes  
**Focus on wellness and prevention reduces incidence / severity of chronic disease and illness** |
| Coordinated                    | Ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. | • Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.  
• Communication and connectedness is enhanced by health information technology | **Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions.** |
| Accessible                     | Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations. | • Implement more efficient appointment systems that offer same-day or 24/7 access to care team  
• Use of e-communications and telemedicine to provide alternatives for face-to-face visits and allow for after hours care. | **Focus on wellness and prevention reduces incidence / severity of chronic disease and illness** |
| Committed to quality and safety | Demonstrates commitment to quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health. | • Use electronic health records and clinical decision support to improve medication management, treatment, and diagnosis.  
• Establish quality improvement goals to maximize data and reporting about patient populations and monitor outcomes | **Focus on wellness and prevention reduces incidence / severity of chronic disease and illness** |
PCMH Growth

- Sites
- Clinicians
A journey to higher quality lower cost
quality as well as efficiency
Australia recognizes evidence in support of Patient-Centered Medical Homes is in, and it’s compelling.

- Improved access to care;
- Improved clinical outcomes;
- Better management of chronic and complex disease;
- Decreased use of inappropriate medications;
- Decreased hospital admissions and readmissions; and
- Improved palliative care services.

Therefore the Australian government will adopt Patient-Centered Medical Home as standard of care.
Survey Of 5 European Countries Suggests Patient-Centered Medical Homes Would Improve Family Medicine Primary Care

2013/03/19

http://content.healthaffairs.org/content/early/2013/03/19/hlthaff.2012.0184.full.html
Patients not shortchanged
PCMH as the Foundation

The right care foundation
The right time
The right price
THANK YOU
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President, Patient-Centered Primary Care Collaborative
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• cell 845 416 700
• 12 Hammer Drive Hopewell Jct, Ny 12533
Onsite Health and Wellness Centers
Thirteen Year Cumulative Percent Change in Cost

<table>
<thead>
<tr>
<th>Year</th>
<th>VHA Cost Per Patient</th>
<th>Average Medicare Payment/Enrollee</th>
<th>Consumer Price Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>-0.4%</td>
<td>6.3%</td>
<td>3.00%</td>
</tr>
<tr>
<td>1996</td>
<td>-0.9%</td>
<td>11.4%</td>
<td>5.37%</td>
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<tr>
<td>1997</td>
<td>-7.9%</td>
<td>9.7%</td>
<td>7.05%</td>
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<tr>
<td>1998</td>
<td>-9.3%</td>
<td>10.8%</td>
<td>9.41%</td>
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<td>1999</td>
<td>-8.9%</td>
<td>15.4%</td>
<td>13.13%</td>
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<tr>
<td>2000</td>
<td>-9.5%</td>
<td>25.9%</td>
<td>16.30%</td>
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<tr>
<td>2001</td>
<td>-10.8%</td>
<td>33.5%</td>
<td>18.16%</td>
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<tr>
<td>2002</td>
<td>-5.9%</td>
<td>40.0%</td>
<td>20.88%</td>
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<tr>
<td>2003</td>
<td>-0.1%</td>
<td>51.7%</td>
<td>24.14%</td>
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<tr>
<td>2004</td>
<td>2.1%</td>
<td>62.9%</td>
<td>28.36%</td>
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<td>2005</td>
<td>4.4%</td>
<td>89.6%</td>
<td>32.47%</td>
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<tr>
<td>2006</td>
<td>15.6%</td>
<td>99.2%</td>
<td>36.18%</td>
</tr>
<tr>
<td>2007</td>
<td>24.1%</td>
<td>111.9%</td>
<td>41.35%</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
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