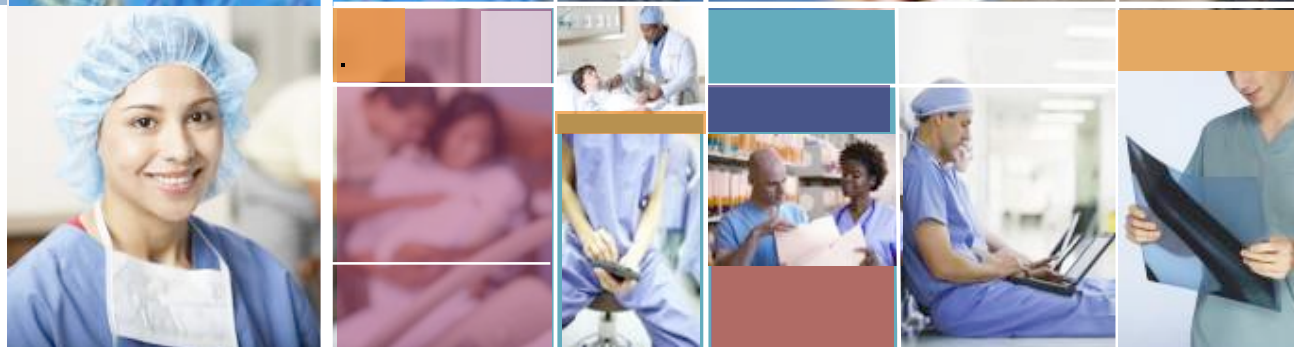


*Patient Centered*  
**PRIMARY CARE**  
*Collaborative*



Patient Centered  
Medical Home



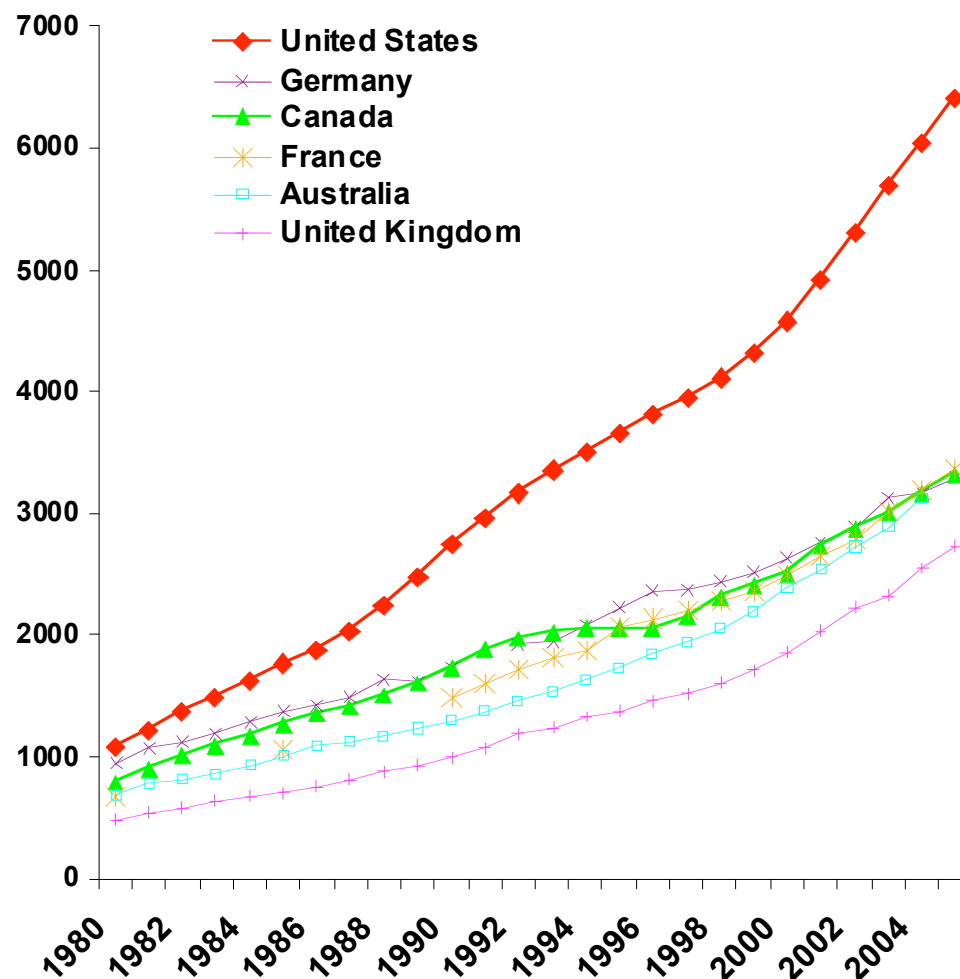
HARVARD

health policy REVIEW

How do you start to fix the foundational issue around why our healthcare system is so expensive and yet so broken??

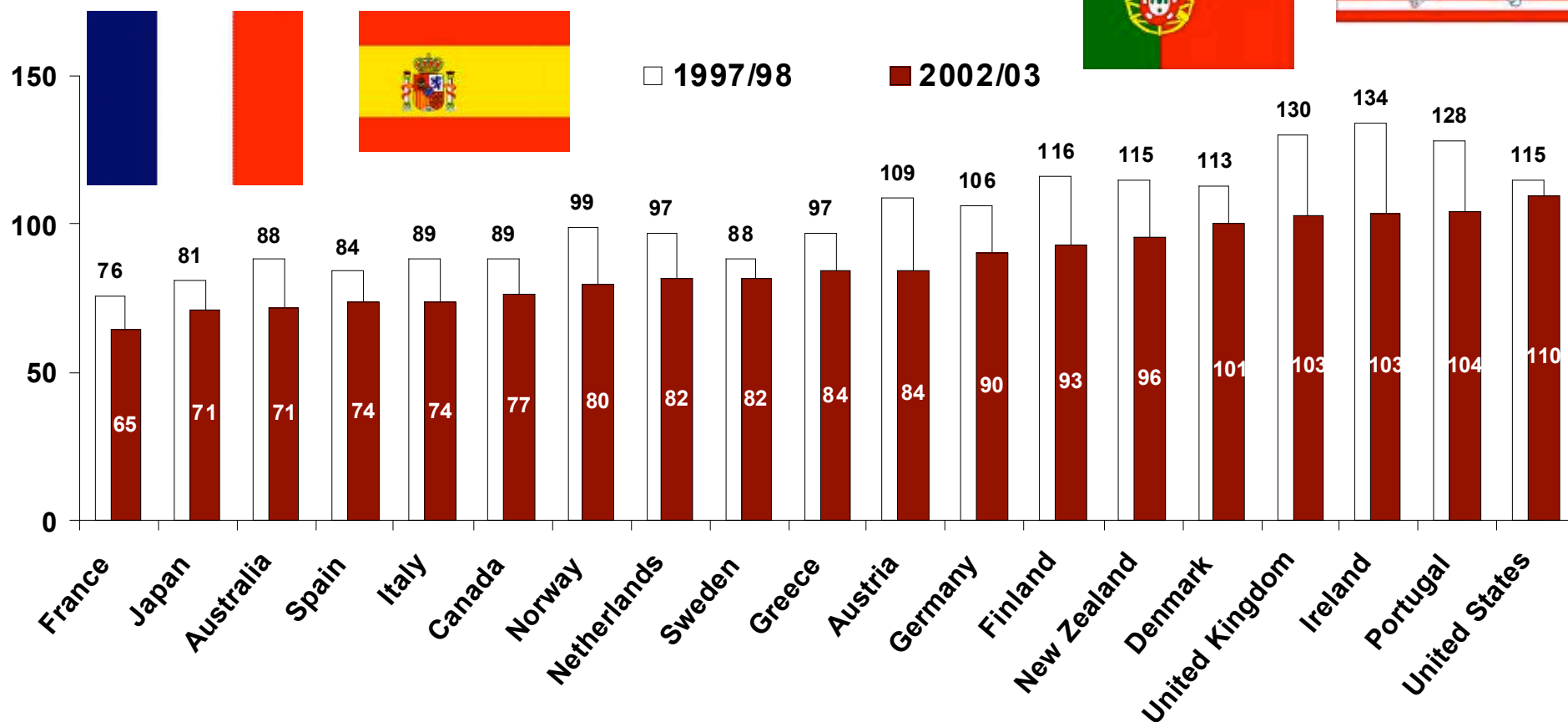


Average spending on health per capita (\$US PPP)



Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

USA worse/19  
37<sup>th</sup> by WHO



Countries' age-standardized death rates, list of conditions considered amenable to health care  
 Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis,  
*Health Affairs*, January/February 2008, 27(1):58-71



“We do heart surgery more often than anyone, **but we need to**, because patients are not given the kind of **coordinated primary care** that would prevent chronic heart disease from becoming acute.”

George Halverson’s (CEO Kaiser)

*Healthcare Reform Now*

## Patient-Doctor Relationship



*Patient-Centered*  
**PRIMARY CARE**  
*Collaborative*

A long-term comprehensive relationship with your Personal Physician empowered with the right tools and linked to your care team can result in better overall family health...

Systems thinking isn't even on the healthcare radar screen –



- *The prevention and the IT is insufficient, the accountability and incentives are not in place - it is not centered on the patient's needs.*
- *This is why we, the Large employers like IBM, created the PCPCC with primary care, and we want to link payment to transformation.*
- *The PCPCC has all the primary care physician group, all the national healthcare plans and most fortune 500*

## TODAY'S CARE

My patients are those who make appointments to see me

Patients' chief complaints or reasons for visit determines care

Care is determined by today's problem and time available today

Care varies by scheduled time and memory or skill of the doctor

Patients are responsible for coordinating their own care

I know I deliver high quality care because I'm well trained

Acute care is delivered in the next available appointment and walk-ins

It's up to the patient to tell us what happened to them

Clinic operations center on meeting the doctor's needs



## MEDICAL HOME CARE

Our patients are those who are registered in our medical home

We systematically assess all our patients' health needs to plan care

Care is determined by a proactive plan to meet patient needs without visits

Care is standardized according to evidence-based guidelines

A prepared team of professionals coordinates all patients' care

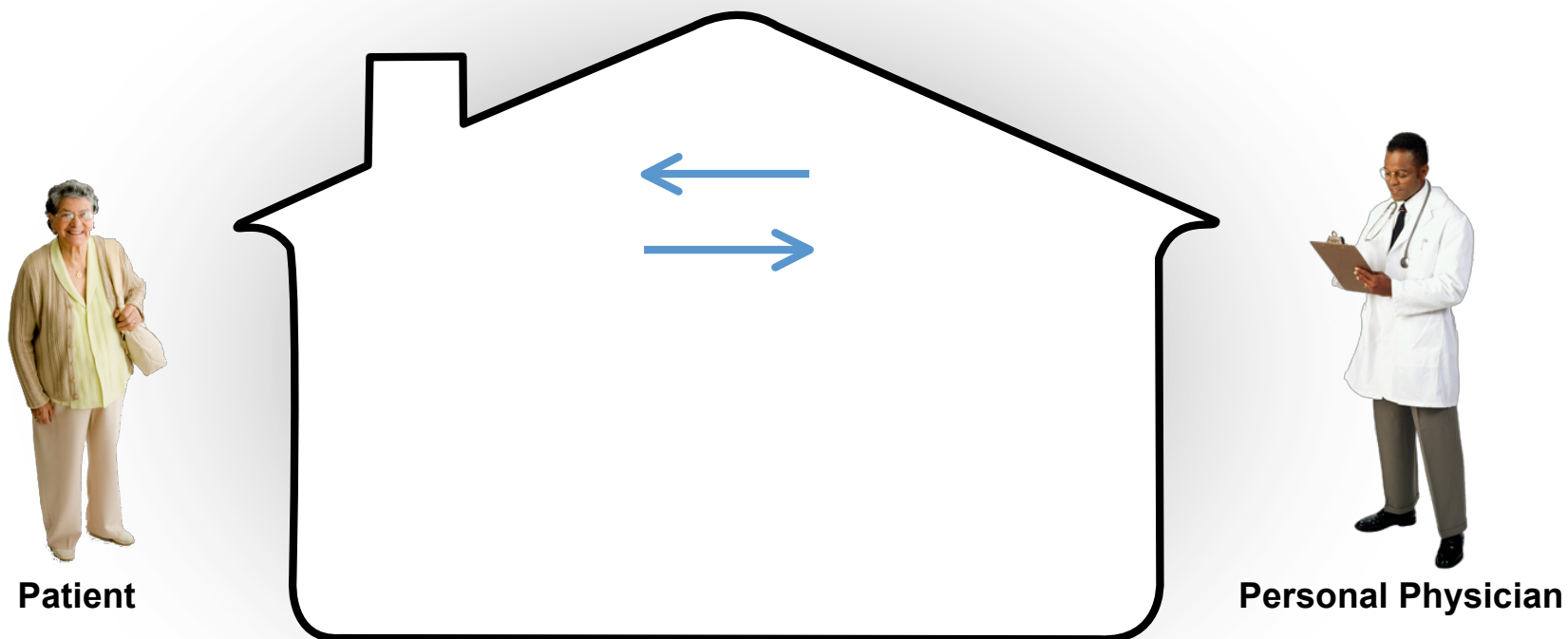
We measure our quality and make rapid changes to improve it

Acute care is delivered by open access and non-visit contacts

We track tests & consultations, and follow-up after ED & hospital

A multidisciplinary team works at the top of our licenses to serve patients

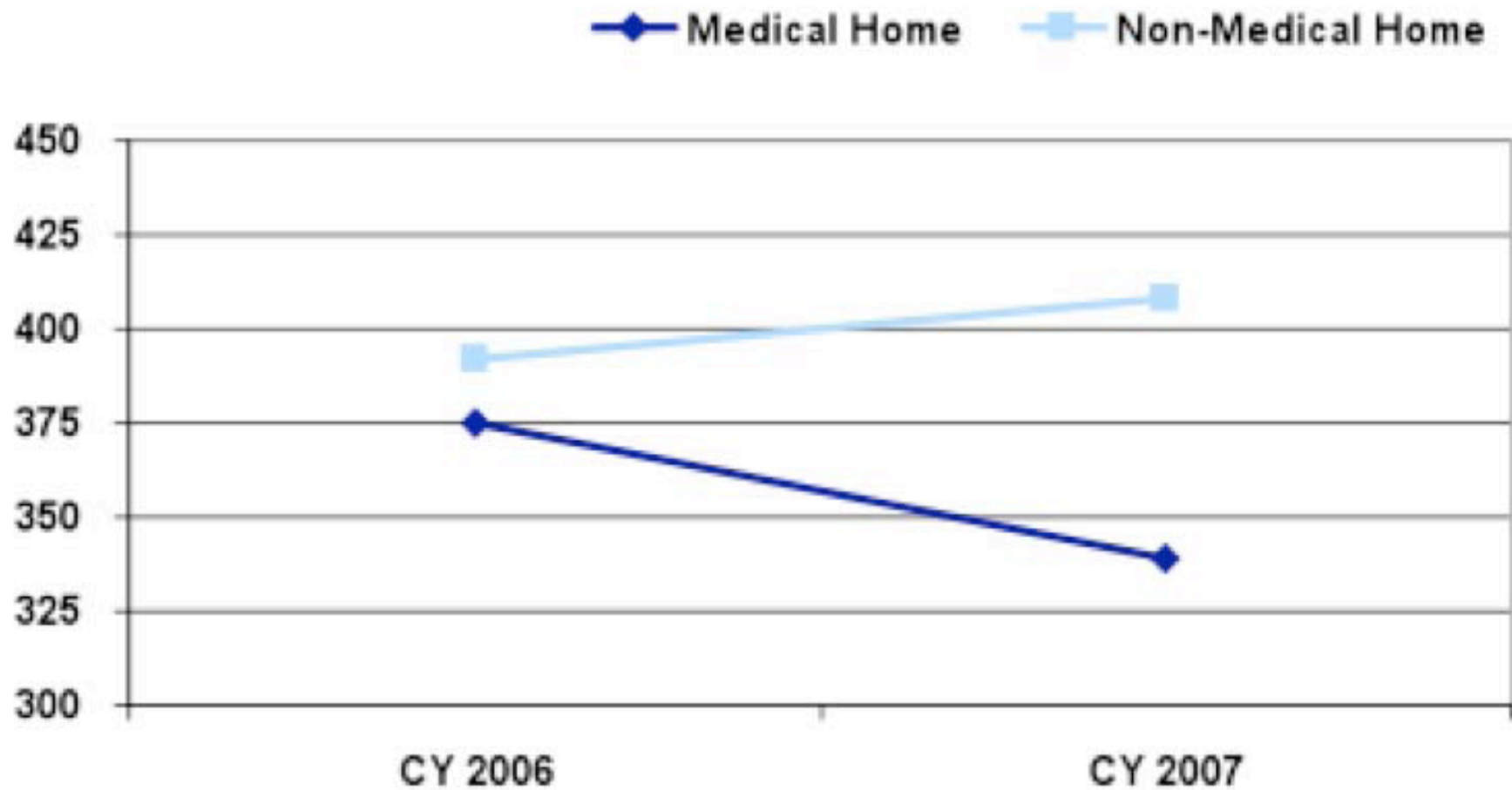
## A New Model of Care that Redesigns the Way Primary Care is Delivered and Financed



- Trusted personal physician
- Physician who provides, manages and facilitates care
- Care is coordinated or integrated across healthcare system
- More accessible practice with increased hours and easier scheduling
- Enhanced payment that recognizes the added value of delivering care through the PCMH model
- Assistance to practices seeking transformation
- Support to practices adopting HIT for QI

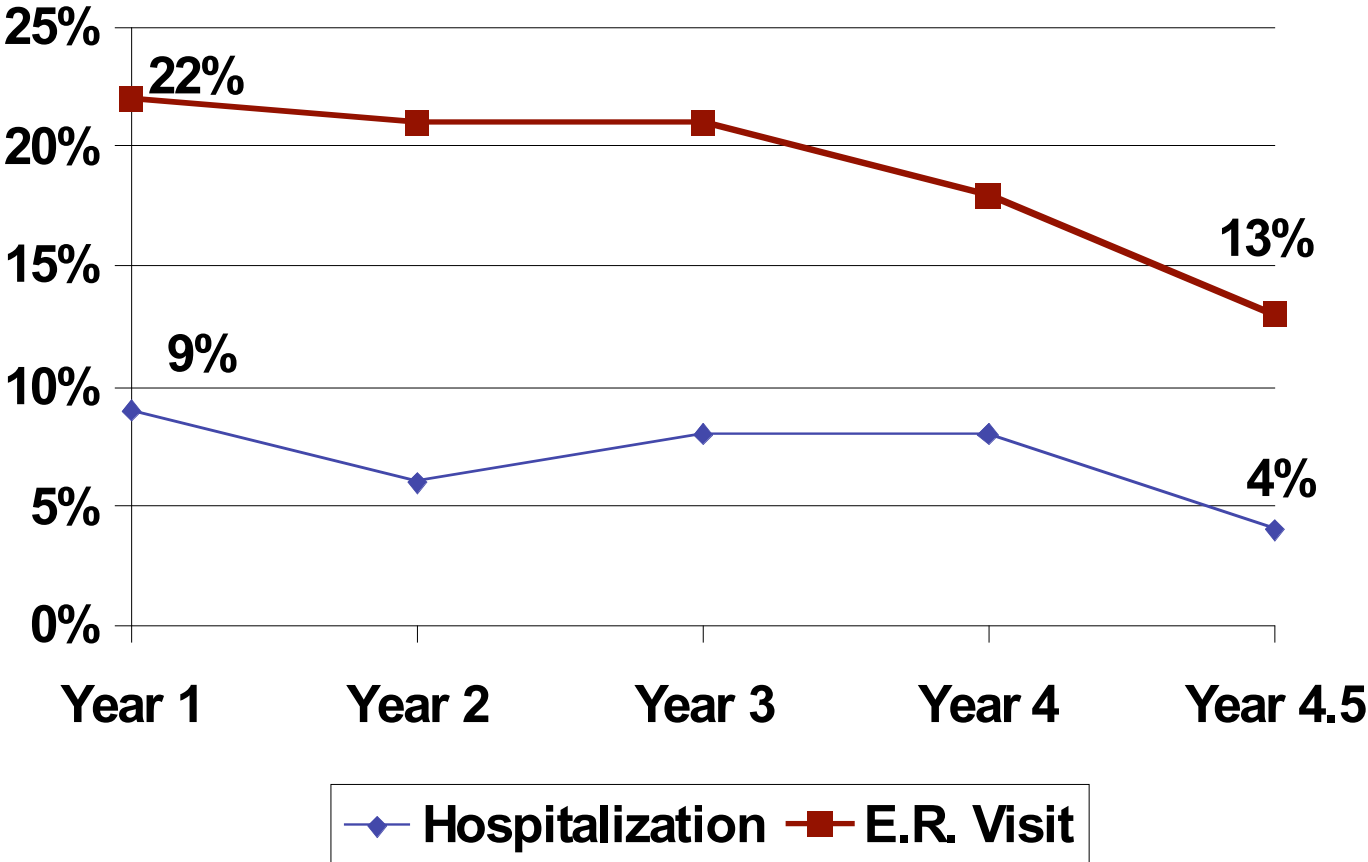
## Geisinger Medical Home Sites and Hospital Admissions

Hospital admissions per 1,000 Medicare patients



Source: Geisinger Health System, 2008.

# Marillac's Integrated Care Patients (PCMH)



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## Conclusion we need to move to action - walk the talk

**“Knowing is not enough...  
We must apply.”  
~Goethe**



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## PAUL GRUNDY MD, MPH, Chairman Patient-Centered Primary Care Collaborative

- Director, Healthcare Transformation
- SUMMARY:
- **Paul Grundy MD, MPH, FACOEM, FACPM is IBM's Director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services and Health Benefits, part of IBM's Corporate Headquarters Human Resources group.**
- **Chairman of the Patient Centered Primary Care Collaborative a coalition he lead IBM in creating in early 2006. The PCPCC is dedicated to advancing a new primary-care model called the Patient-Centered Medical Home as a means of fundamentally reforming healthcare delivery, which in turn is essential to maintaining US international competitiveness. Today, the PCPCC represents employers of some 50 million people across the United States as well as physician groups representing more than 330,000 medical doctors, leading consumer groups and, most recently, the top seven US health-benefits companies.**
- Prior to joining to IBM, Dr Grundy worked as a senior diplomat in the US State Department supporting the intersection of health and diplomacy. He was also the Medical Director for the International SOS, the world's largest medical assistance company and for Adventist Health Systems, the second-largest not-for-profit medical system in the world.
- Dr. Grundy attended medical school at the University of California San Francisco and trained at Johns Hopkins University. He has work extensively in International Aids Pandemic, including writing the United States' first piece of legislation addressing AIDS Education in Africa.
- Dr. Grundy presently serves on The Medical Education Futures Study National Advisory Board and is Chairman of the Patient-Centered Primary Care Collaborative (PCPCC), Dr Grundy is also the Chair of Health Policy of the ERISA Industry Committee.