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

USA worse/19
37th by WHO

Countries’ age-standardized death rates, list of conditions considered amenable to health care
“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

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
<table>
<thead>
<tr>
<th>TODAY’S CARE</th>
<th>MEDICAL HOME CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
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<tr>
<td>Patients’ chief complaints or reasons for visit determines care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
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<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 without visits</td>
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<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
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<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>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>Acute care is delivered in the next available appointment and walk-ins</td>
<td>Acute care is delivered by open access and non-visit contacts</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>
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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

- Medical Home
- Non-Medical Home

Source: Geisinger Health System, 2008.
Marillac’s Integrated Care Patients (PCMH)

- Hospitalization
- E.R. Visit

Year 1: 22% Hospitalization, 13% E.R. Visit
Year 2: 9% Hospitalization, 13% E.R. Visit
Year 3: 10% Hospitalization, 13% E.R. Visit
Year 4: 5% Hospitalization, 13% E.R. Visit
Year 4.5: 4% Hospitalization, 13% E.R. Visit

Hospitalization tends to decrease over time, while E.R. visits remain relatively stable.
Conclusion we need to move to action - walk the talk

“Knowing is not enough… We must apply.”
~Goethe
R.S. Galvin and S. Delbanco, “Between a Rock and a Hard Place: Understanding the Employer Mind-Set,” 


K. Grumbach and T. Bodenheimer, “A Primary Care Home for Americans: Putting the House in Order,” 


ACP, “The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation’s Health” (Philadelphia: ACP, 30 January 2006).


Bibliography

REFERENCES


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.