Patient Centered PRIMARY CARE Collaborative

The National Medical Home Summit

The Leading Forum on the Development and Implementation of the Patient Centered Medical Home

A Hybrid Conference, Internet Event and Training Tool

IBM

Paul Grundy MD,MPH
IBM Director
Healthcare
Transformation

The Role of the Employer in the Patient-Centered Primary Care Model

2 and 3 March 2009

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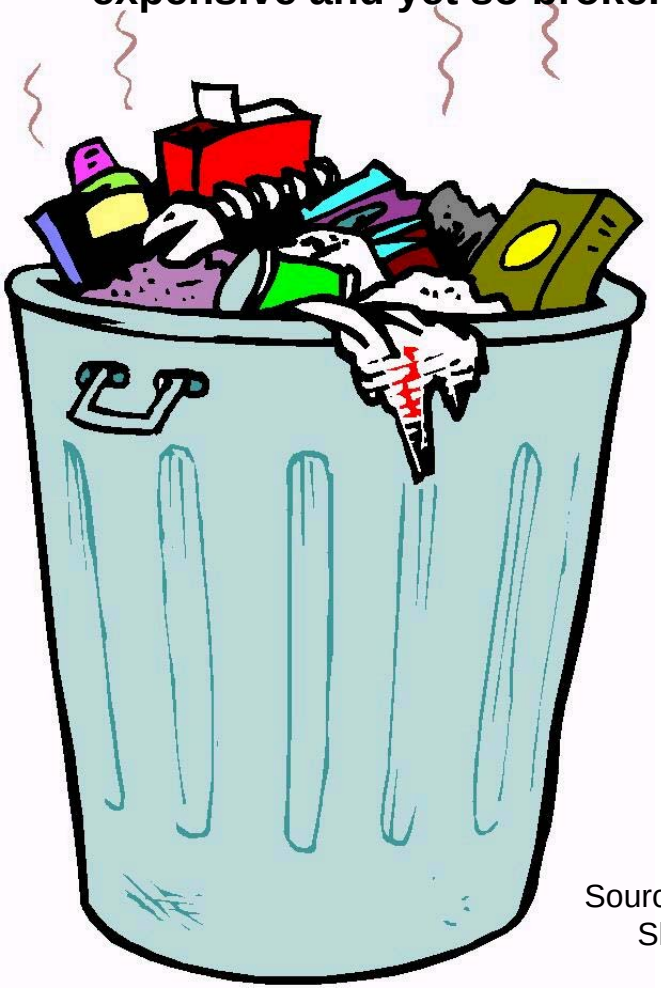
Discussion Objectives

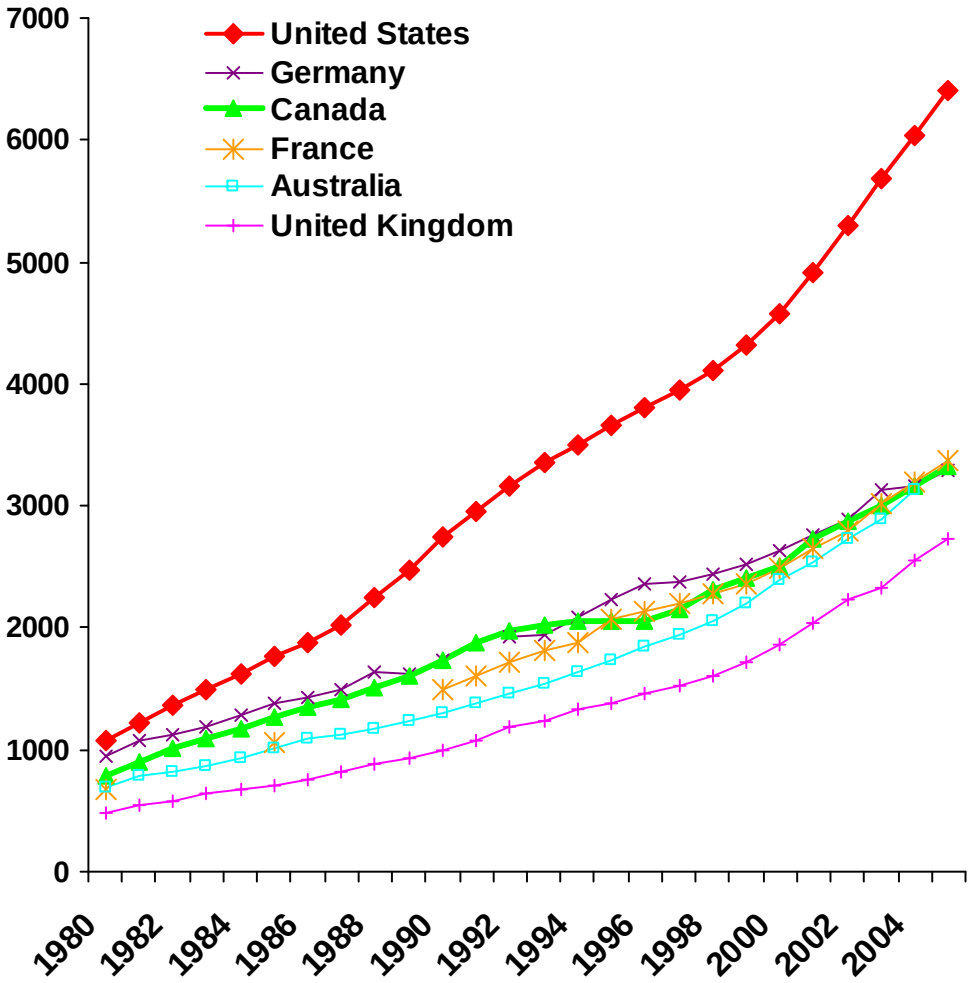
- **Understand Why -- Healthcare the employer- buyer now gets is frankly unacceptable Garbage now !! And why we are part of the problem!!**

- **Learn how Providers, Employers Healthcare Plans are focused on comprehensive care focused on the patient's needs as the foundation for much better healthcare delivery, and what we the employer-buyer wants to buy.**

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

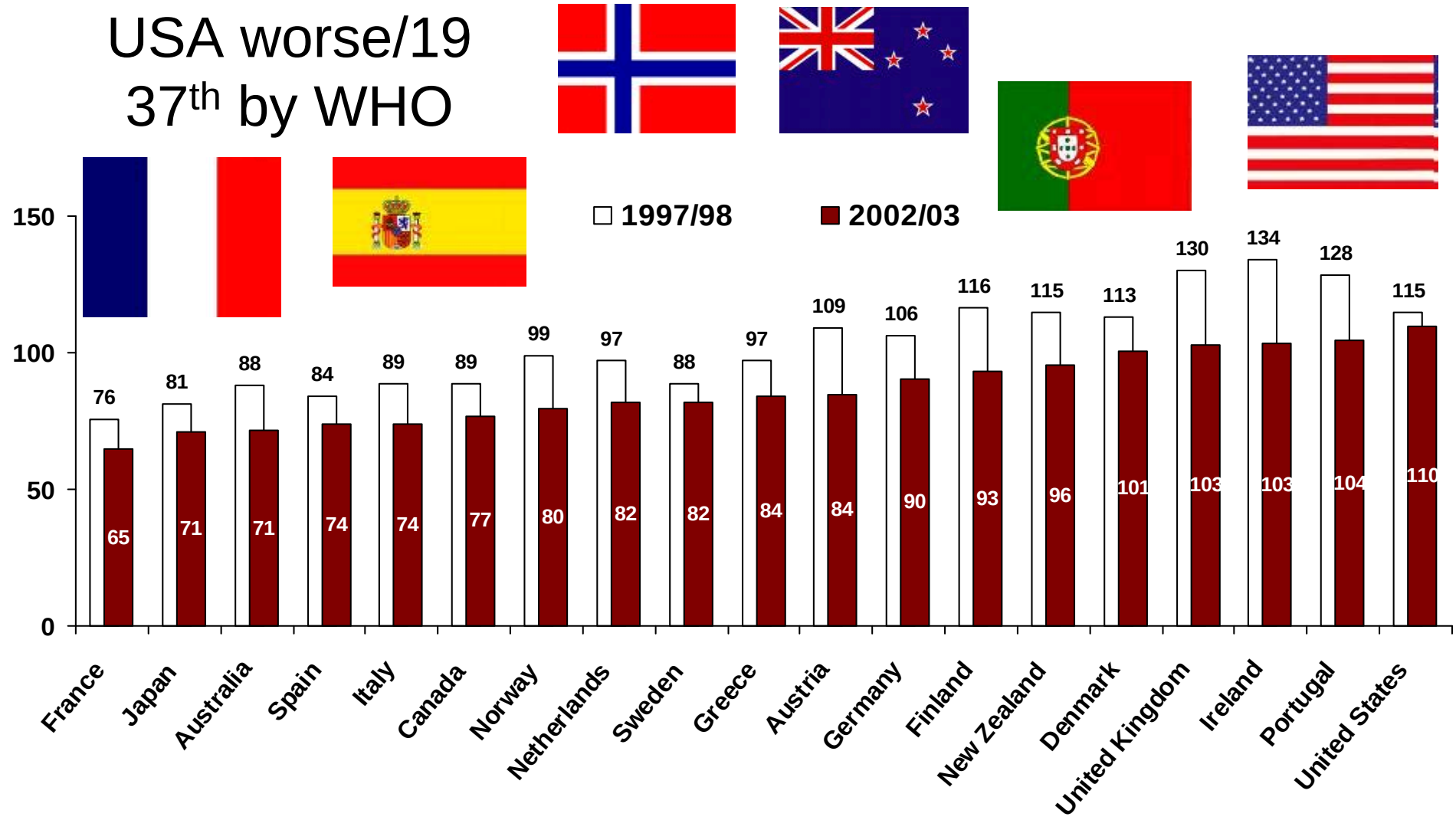


Average spending on health per capita ($US PPP)



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
37th 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 (1) **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 technology, tools and part of your care team can result in better overall family health…

YET

Most Patients Unable to Identify Their Physicians, Survey Finds

75 percent of the patients were unable to name a single doctor assigned to their care. Of the 25 percent who responded with a name, only 40 percent were correct

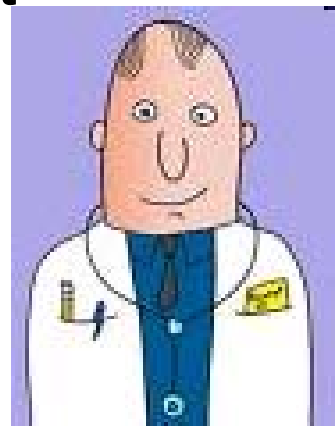
New York Times

KAREN BARROW

Published: January 29, 2009

http://www.nytimes.com/2009/01/30/health/30patients.html?ref=health

Arch Intern Med.2009; 169: 199-201.



DR. WHO?

- **If the U.S. is serious about closing the quality chasm, it will need a strong primary care system, which requires fundamentally reforming provider payment, encouraging all patients to enroll in a patient-centered medical home, and supporting physician practices that serve as medical homes with the information technology and technical assistance for redesigning care processes.**

Karen Davis Senate HELP
January 29, 2009

Conversation IBM CEO and President Obama

There is little benefit in merely converting individual doctor's offices from paper to computer More important is the effect that IT investment will Have on the care provided to individual patients. With electronic records, primary care doctors will have the knowledge that they need about each patient to make treatment most effective and to coordinate care with specialists, hospitals and the patients themselves. and doctor,

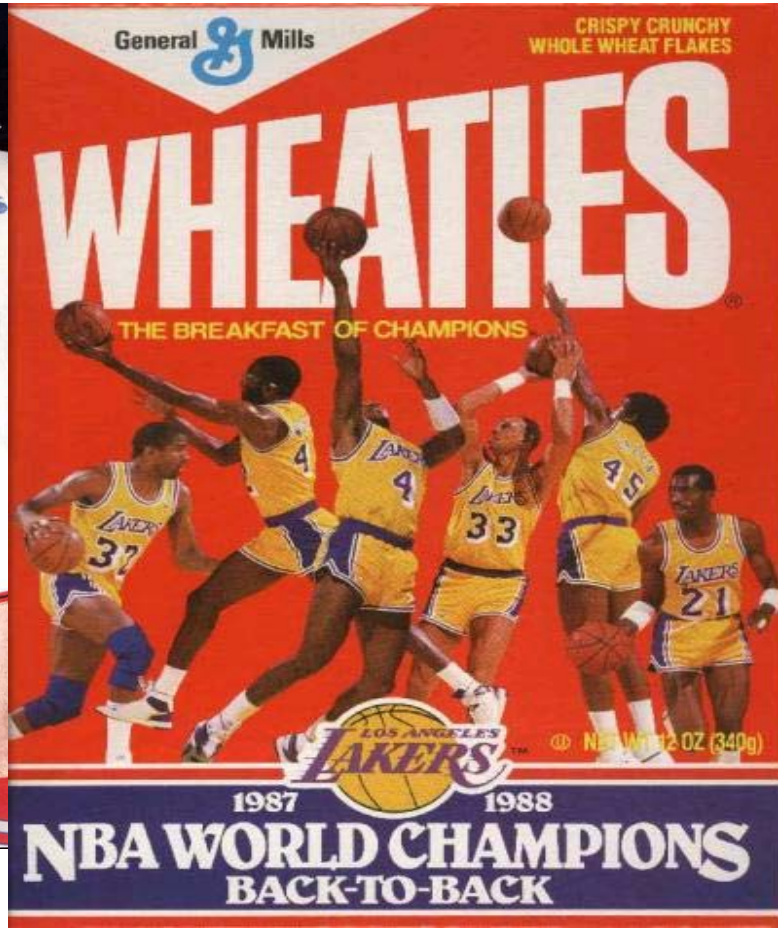
By focusing on primary care, we can move U.S. health Care toward a system that promotes wellness and prevention

ROLL CALL

January 29, 2009,

Baucus- Health Care Reform Proposal Nov 2008

- **Expanding Medicare's role in testing the medical home model — in which practitioners are paid explicitly for comprehensive care management services…**
- **Medical home expansions in Medicare should focus only on providers who are committed to ensuring that patients truly receive the primary care and care management services...**
- **Providers seeking to participate in a Medicare medical home… should meet a set of stringent service and capacity criteria in order to qualify… and be willing to have additional payments based in part on the quality of care they deliver.**



We Do NOT know how to play as a team

“ We don't have a healthcare delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure and for individual patients."

The way we as employers buy Healthcare Is part of the Problem

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.*
- *There is no foundation of integrated compressive primary care.*
- *This is why we, the Large employers like IBM, created the PCPCC with primary care, and we want to link payment to transformation.*

Why Patient Centered Medical Home

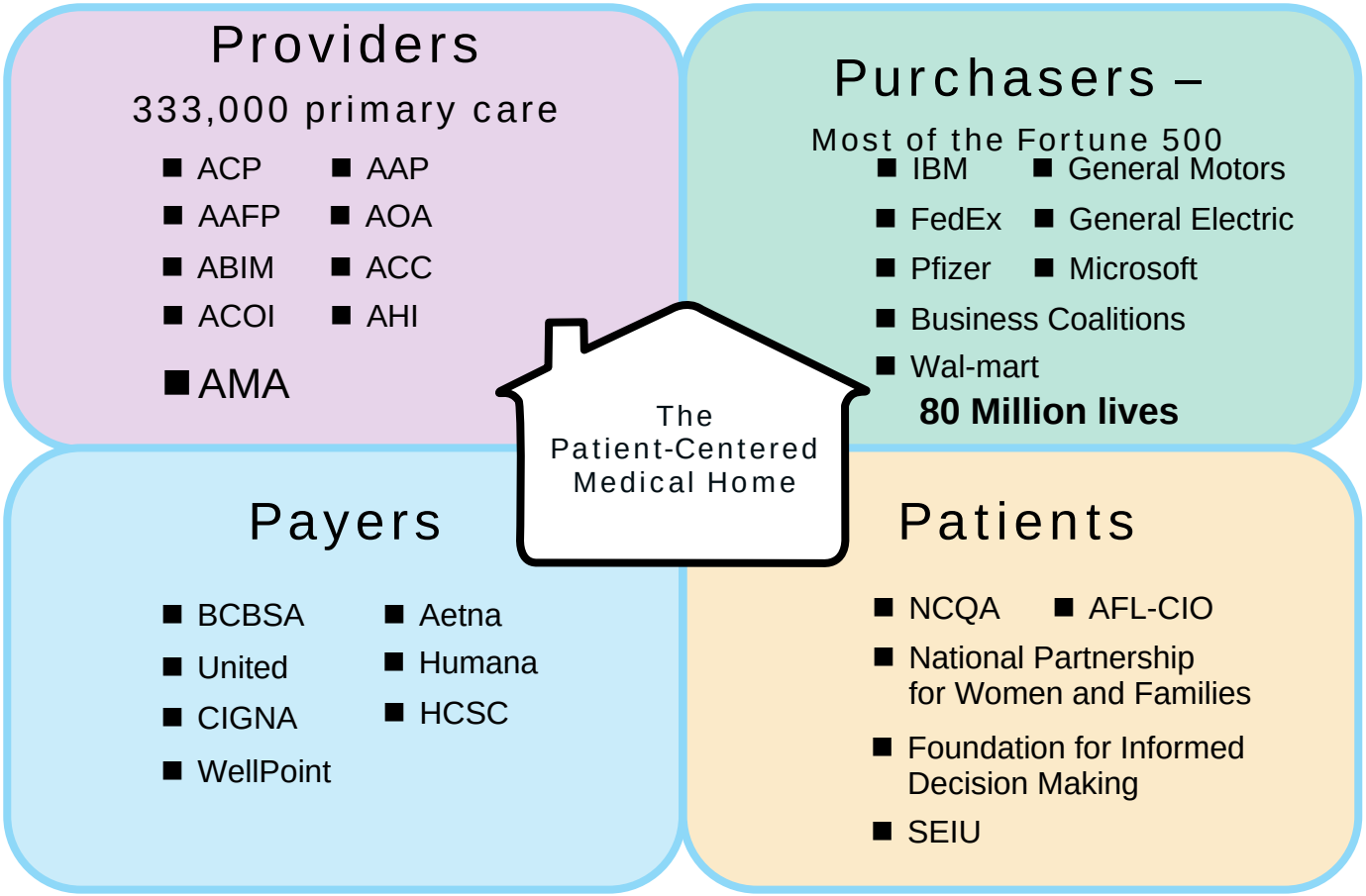
- **The Patient Centered Medical Home creates a framework for change**
- **The Patient Centered Medical Home creates a common language for change**
- **The Patient Centered Medical Home creates an opportunity for change**

Characteristics of the Patient Centered Medical Home: A foundation

- **Personal Relationship: Each Patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.**
- **Team Approach: The Personal Physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing patient care.**
- **Comprehensive: The personal physician is responsible for providing for all the patient's health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals.**
- **Coordination: Care is coordinated and integrated across all domains of the health care system, facilitated by registries, information technology, health information exchange and other means to assure that patient get the indicated care when and where they want it.**
- **Quality and Safety: Quality and Safety are hallmarks of the medical home. This includes using electronic medical records and technology to provide decision-support for evidence-based treatments and patient and physician involvement in continuous quality improvement.**
- **Expanded Access: Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.**
- **Added Value: Payment that appropriately recognizes the added value provided to patients who have a Patient-Centered Medical Home**

The Patient-Centered Primary Care Collaborative

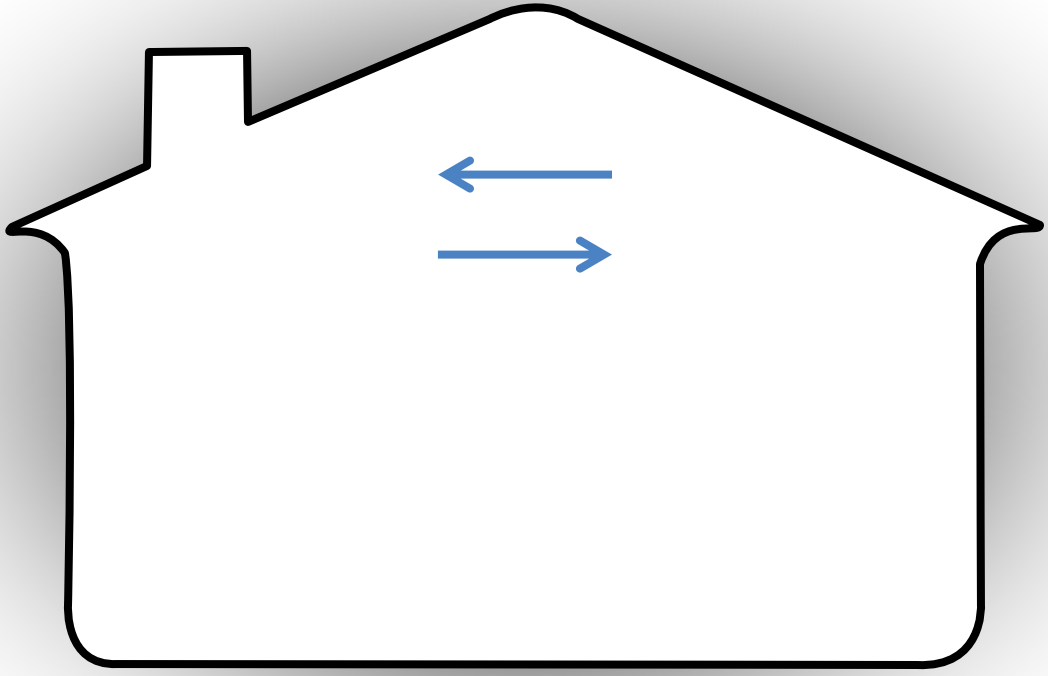
Examples of Broad Stakeholder Support & Participation



MEDICAL HOME
FAMILY COUNSELING
I HAVE AN IDEA... LET'S ALL HAVE A BIG GROUP HUG!!
INSURERS
SPECIALIST

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

Patient

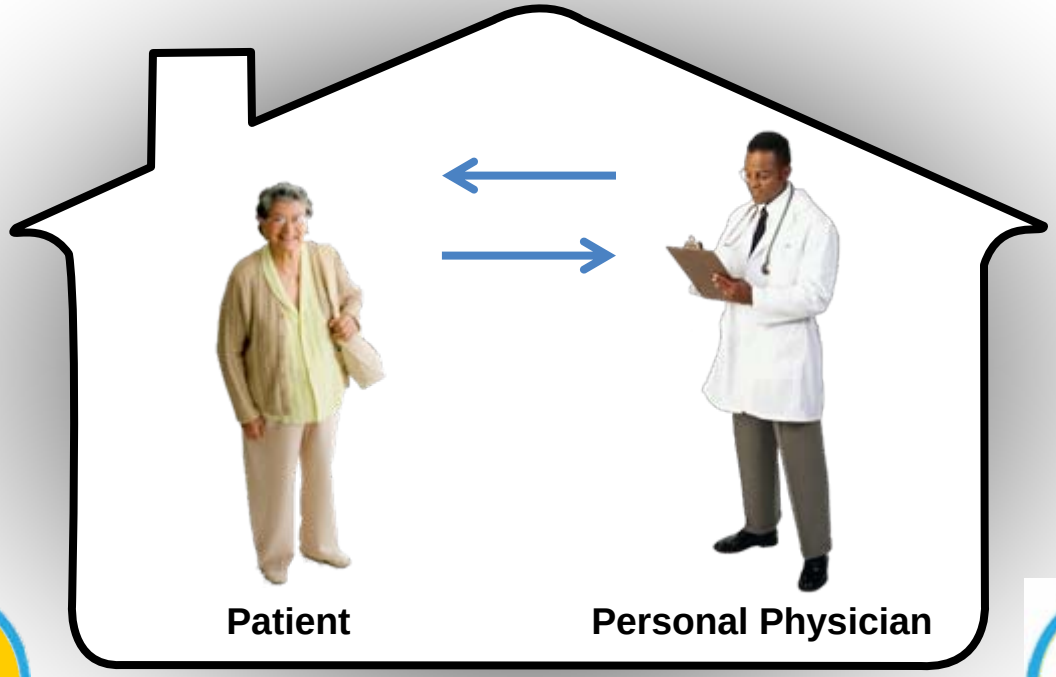


Personal Physician

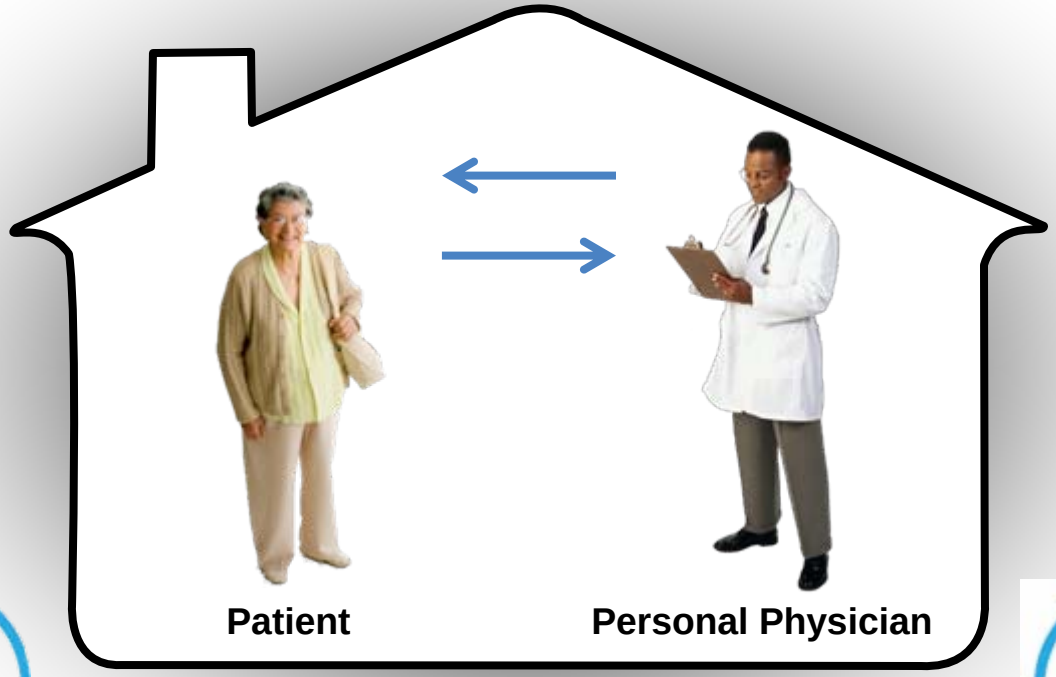
- Trusted personal physician
- Physician who provides, manages and facilitates care
- Care is coordinated or integrated across healthcare system
- More accessible practice with increased hours and easier scheduling

- 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

Not Defined by any Certain Specialty



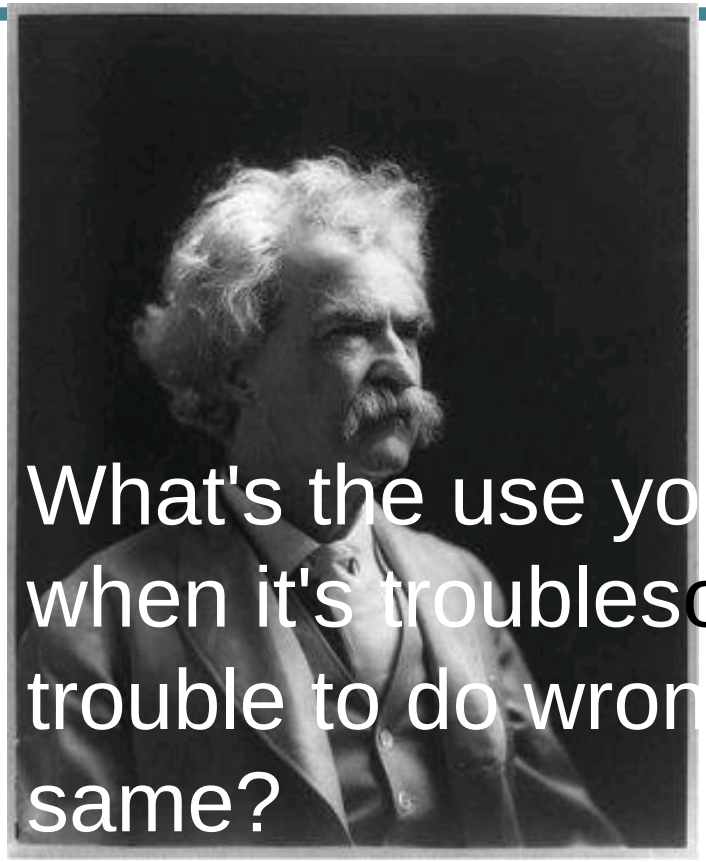
Physician as Facilitator, Not a Gatekeeper



Specialist Care

Hospital Care

Pharmacist Care



What's the use you learning to do Right when it's troublesome to do right and ain't no trouble to do wrong, and the wages is just the same?

Economic incentives significantly influence health care in frequently perverse and completely unintended ways

THE ADVENTURES OF HUCKLEBERRY FINN
by: Mark Twain

Changes in Clinician Incentives

Blended Payment

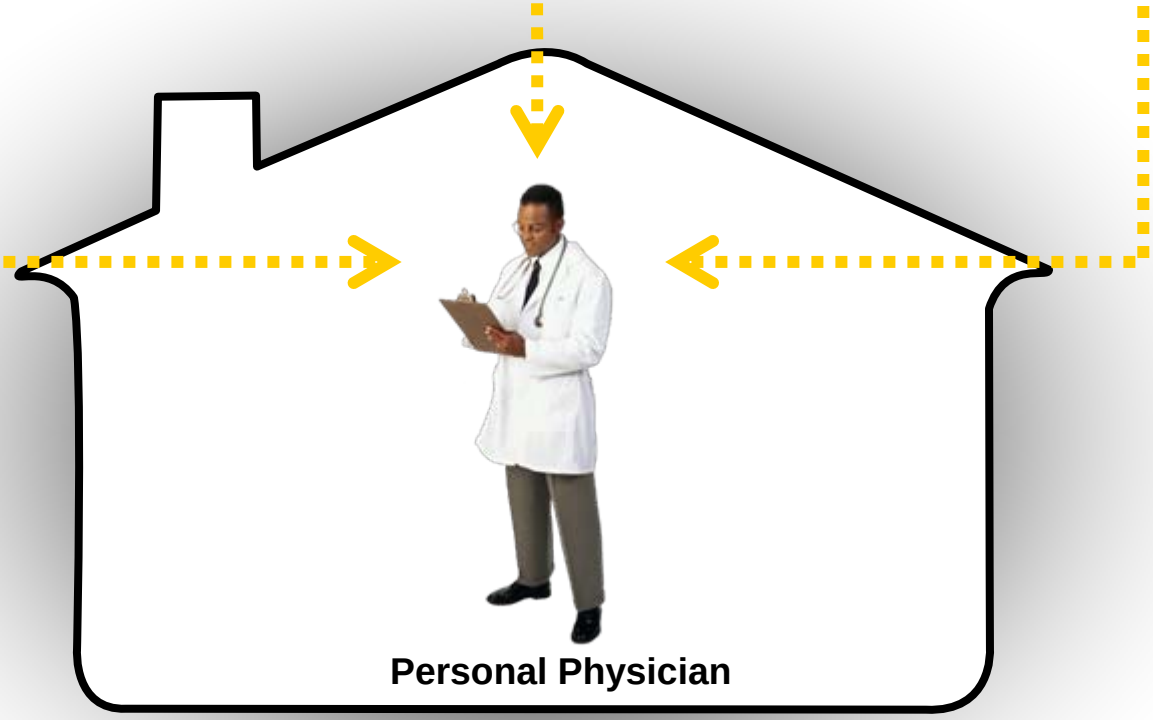
- Fee for service
- Prospective payment
- Pay for outcomes

Better Work Environment

- Team effort
- Increased responsibility for admin and clinicians

Improved Patient Interaction

- More time for patients
- Better communication and access
- Case management



Stakeholder Perspectives

What the PCMH Means to Them

Patients

Clinicians

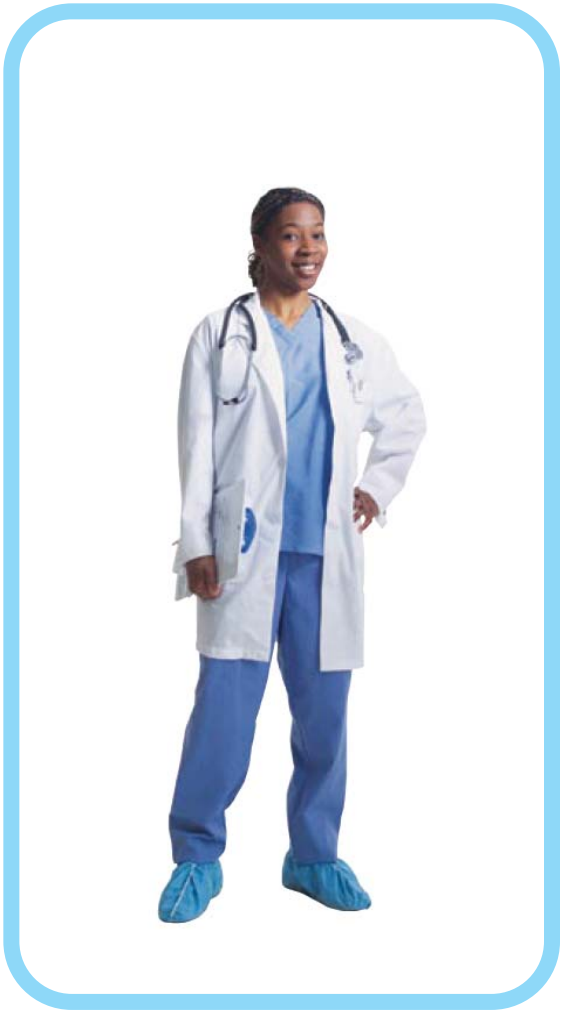
Employers/ Plan Sponsors

PCMH Benefits for Patients

- **Help from a trusted resource in navigating what can be a complex system of care**
- **More resources for better-informed healthcare decisions**
- **Safe, effective care delivered with compassion**
- **Healthier outcomes**
- **Empowered with a better relationship with their doctor and health plan**

PCMH Benefits for Clinicians

- **Better supported by health plans to deliver quality care to patients**
- **Through a shift in incentives, able to more effectively provide wellness and preventative care, which can lead to better outcomes**
- **Fair compensation tied to the additional services provided in the PCMH model as well as reward for improved clinical outcomes**

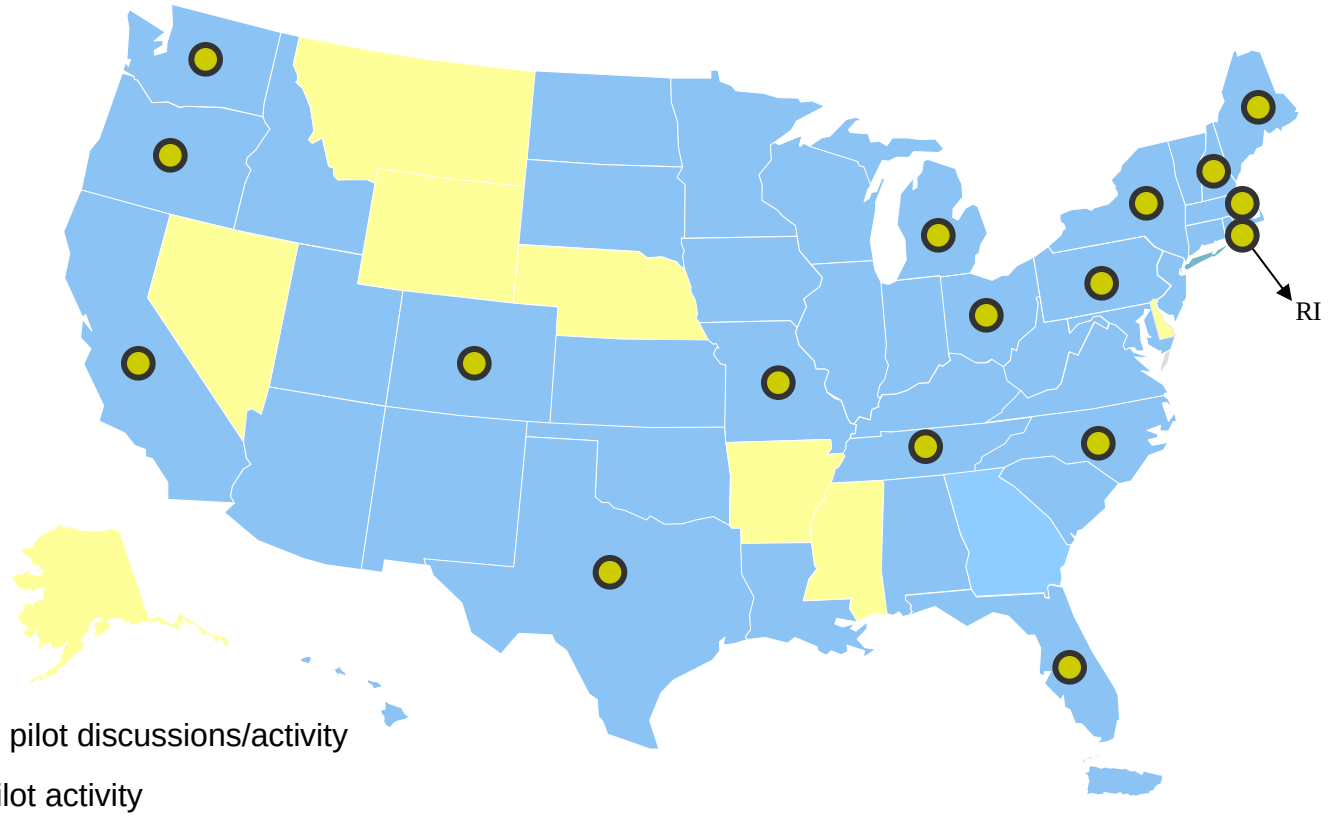


PCMH Benefits for Employers

- **Purchase healthcare based on value and potentially see cost savings associated with more efficient healthcare**
- **Programs led by clinicians and their care teams stress the importance of wellness and prevention in creating healthier employees**
- **A more present and productive workforce**

Patient-Centered Medical Home

Overview of Current Pilot Activity and Planning Discussions (as of April 2008)



Media Attention

The Des Moines Register

Primary-care doctors and health system reformers are predicting that a new way of providing health care should provide better, cheaper results.

The idea, called medical homes, combines traditional notions of family physicians with modern technology. It has caught the attention of medical leaders, insurance companies and politicians.

– 3/18/2008

USA TODAY

The pay boost rewards doctors who reshape their practices to recreate an era when a trusted family physician helped patients through hospitalizations, coordinated specialist care and provided routine screenings. Such efforts may save money by reducing hospitalizations, ER visits and disease.

– 7/14/2008

The New York Times

Health policy experts say that unless payment and practice rules are changed, the financial squeeze on primary care doctors threatens to a crisis for patient care.

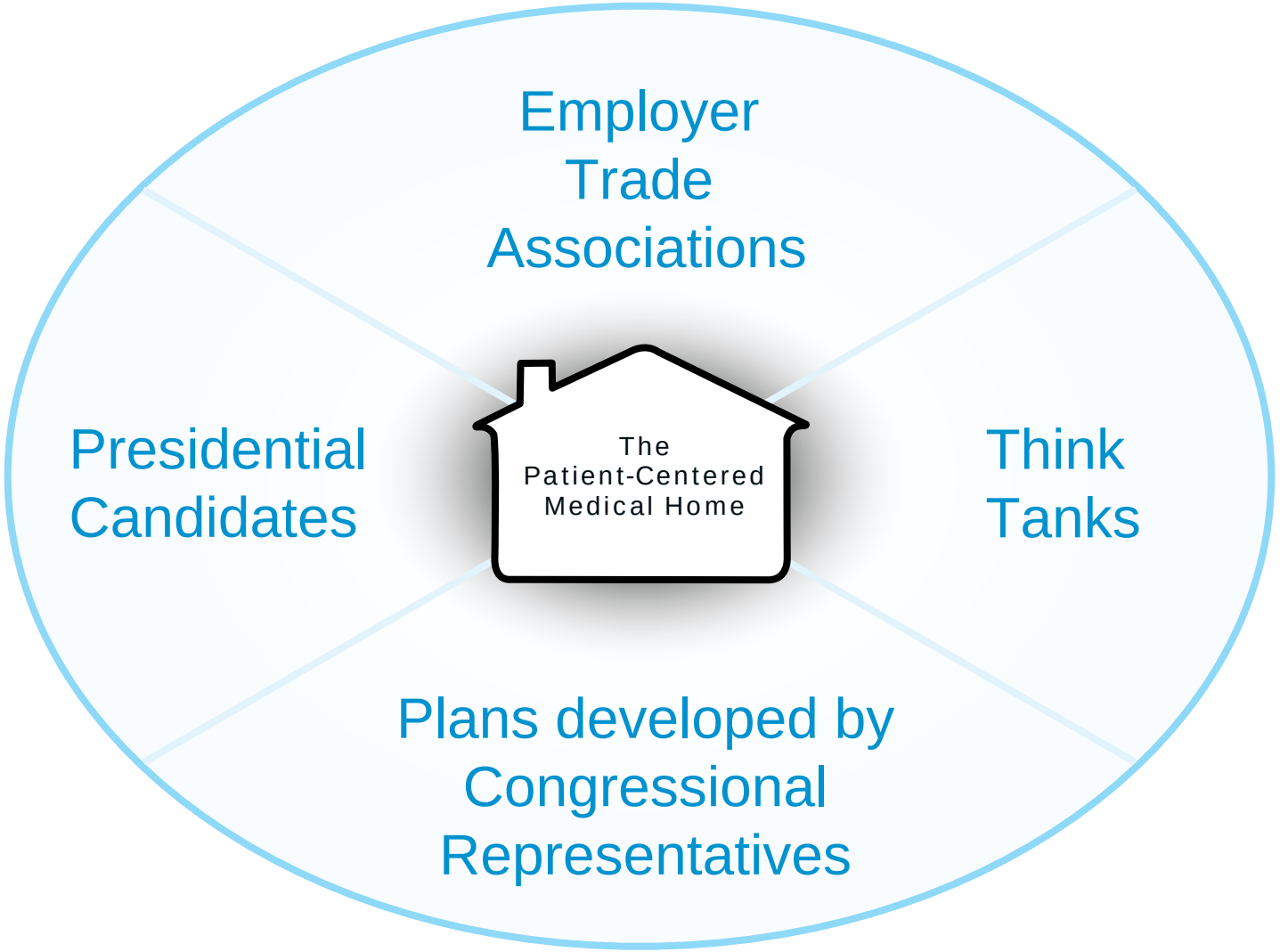
– 11/7/2007

JAMA®

The resurgence of patient and purchaser interest in primary care is leading to the support of some innovative practice models, largely outside the academic health centers. One is the patient-centered medical home.

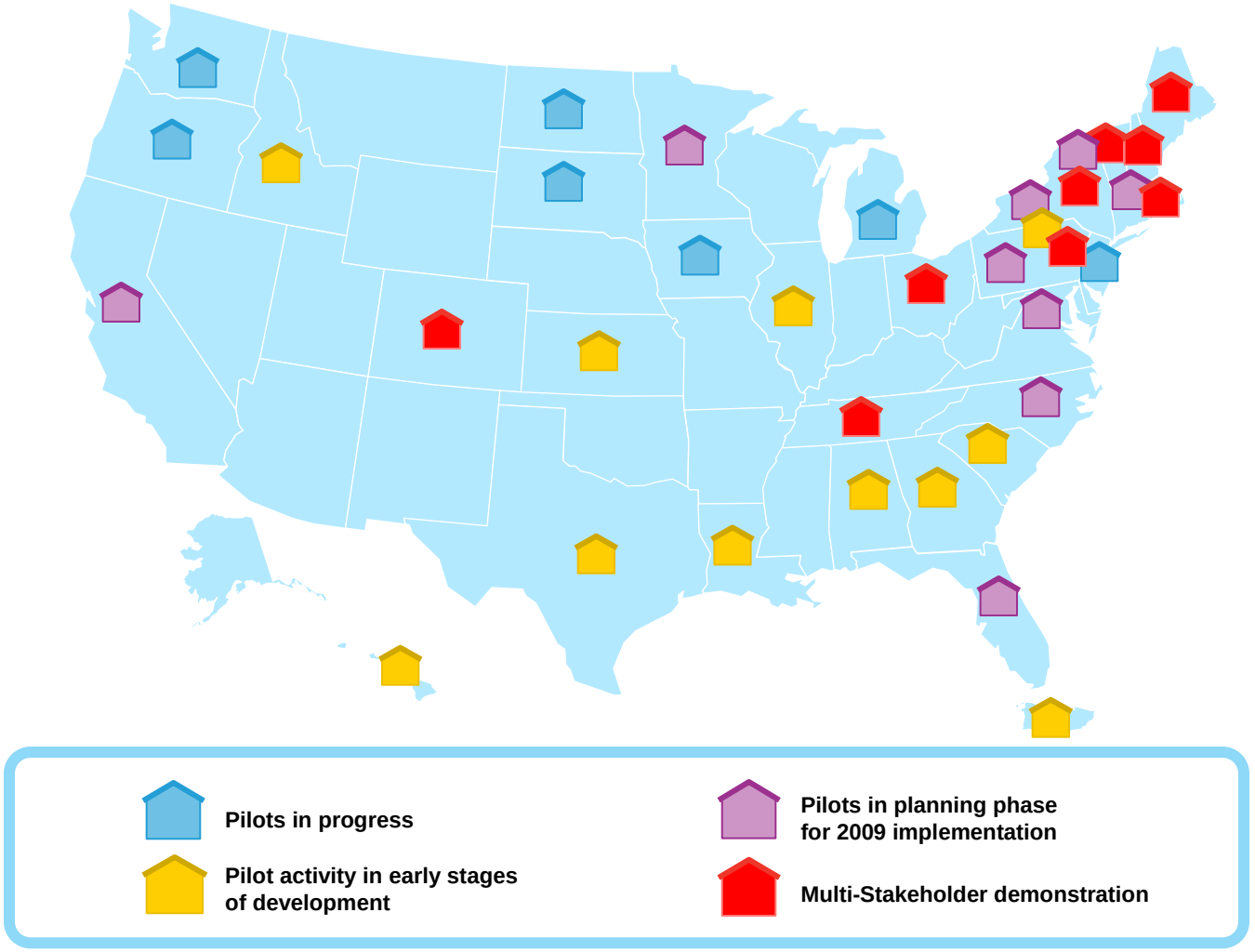
– 04/2008

PCMH in Health Reform Efforts



Patient-Centered Medical Home Demonstrations

Blue Cross Blue Shield Plan Pilots (as of October 2008)



BlueCross BlueShield of North Dakota

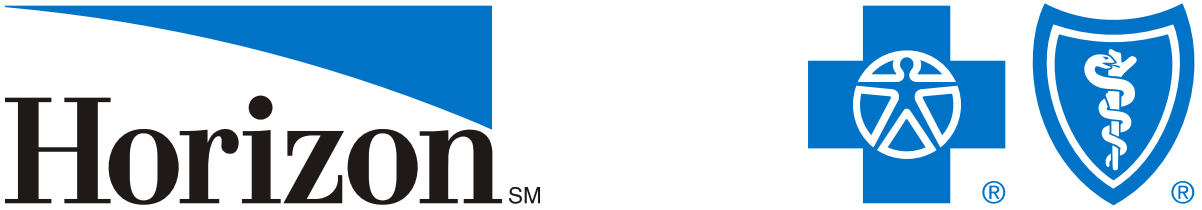
An Independent licensee of the Blue Cross & Blue Shield Association

6% decrease in hospital admissions

24 % decrease emergency room

$500, Per member per years savings

Horizon Blue Cross Blue Shield/Partners In Care

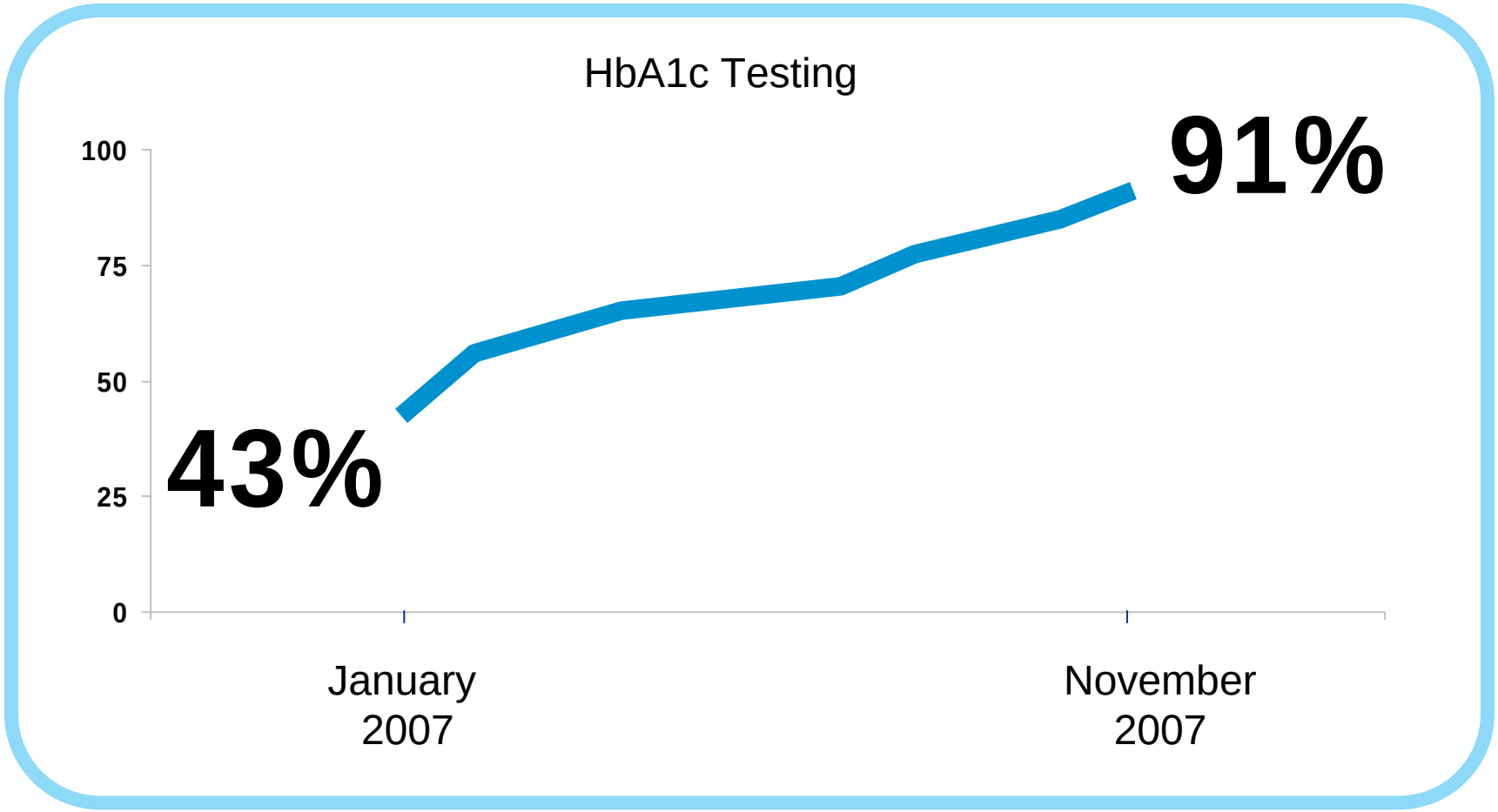


Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work*SM

For the New Jersey State Health Benefits Program

Results: Clinical Process Metric Improvement

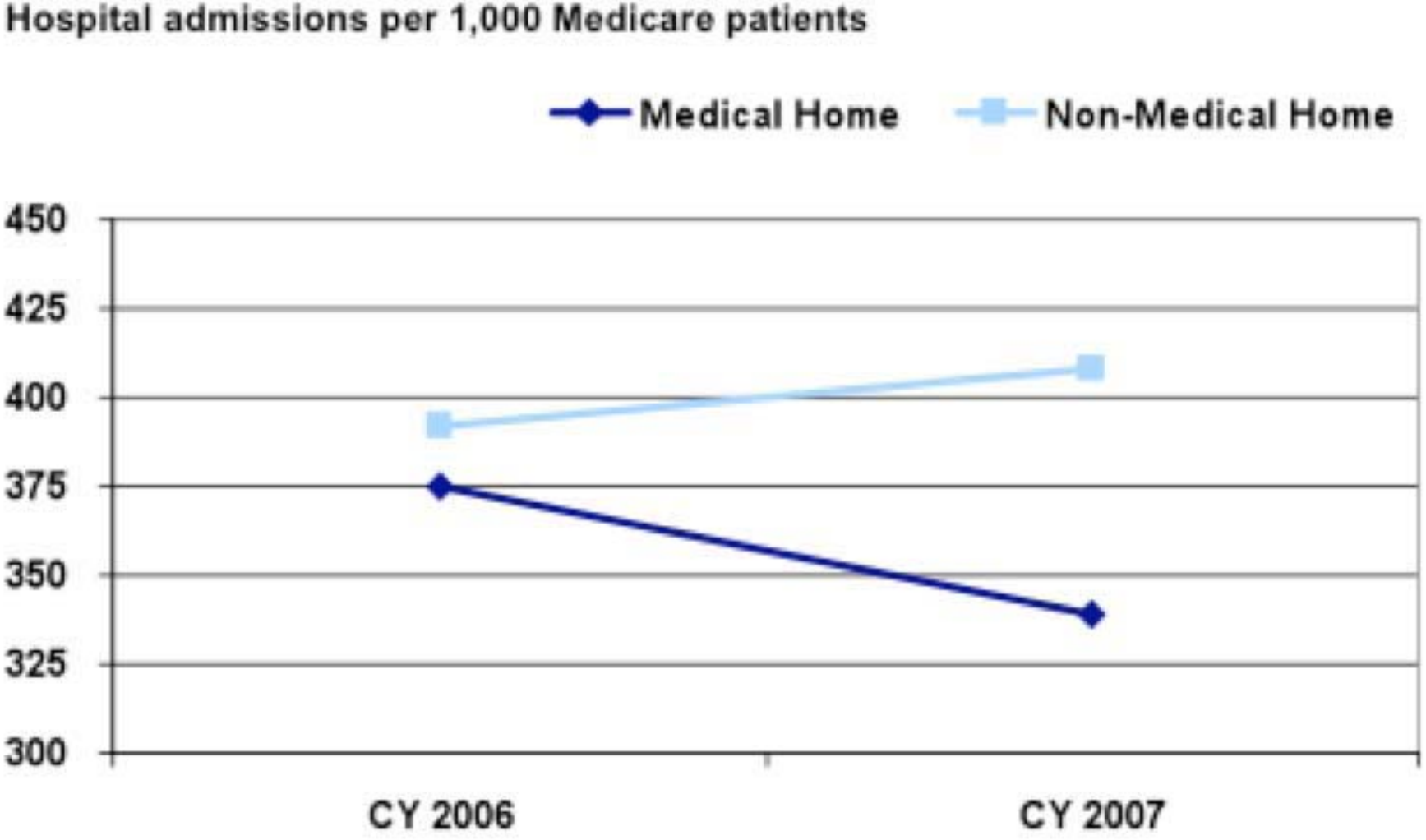


Permission from Horizon Blue Cross Blue Shield and Partners in Care, Corp.

Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work

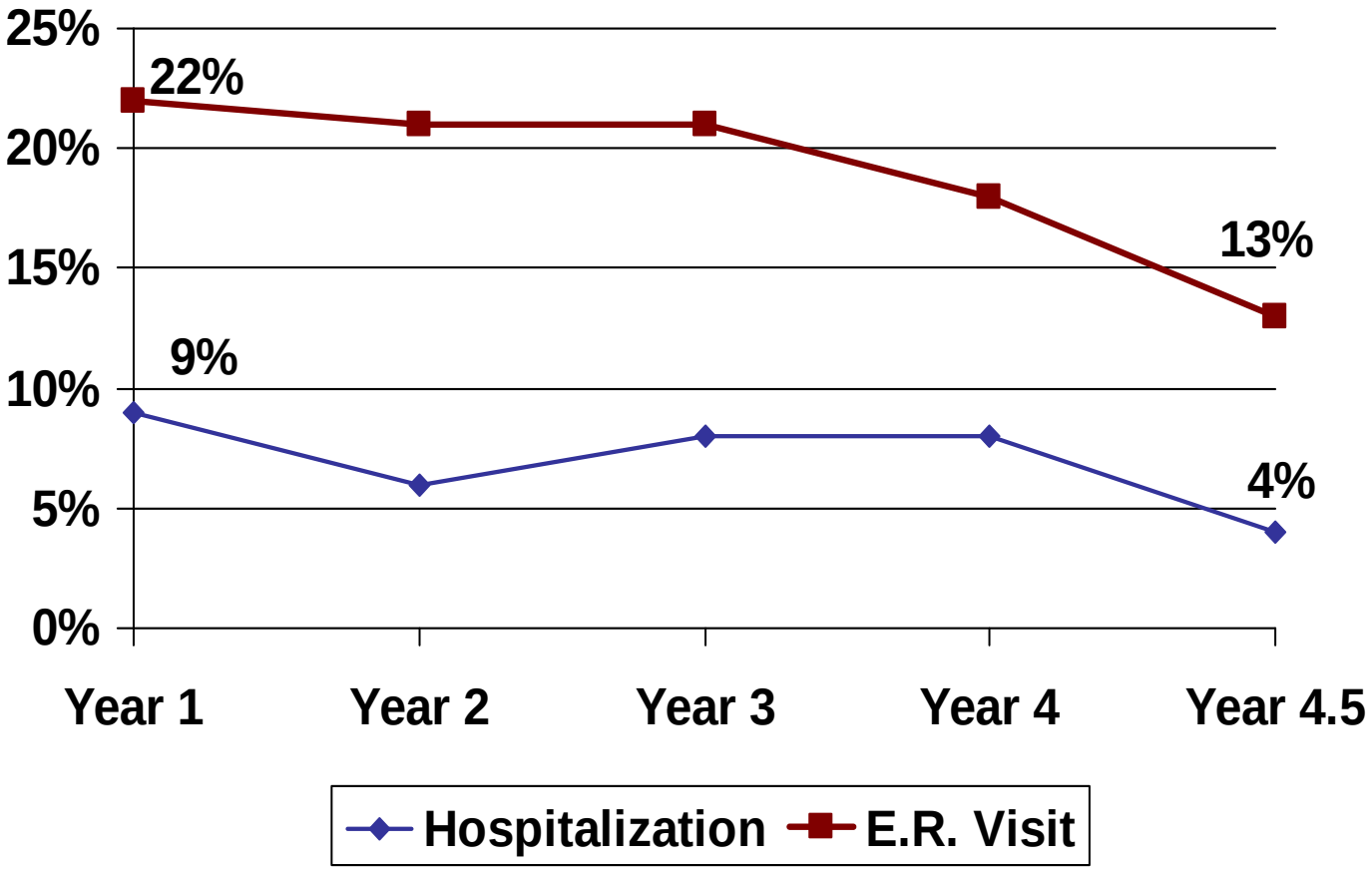
Lewisburg Pennsylvania	preTest period Jan - Oct 2006	First pilot year Jan – Oct 2007	Percent reduction
Hospital Admission	365/1000	291/1000	-20%
Hospital readmissions	15.2%	7.9%	-48%
Cost			7% less

Geisinger Medical Home Sites and Hospital Admissions



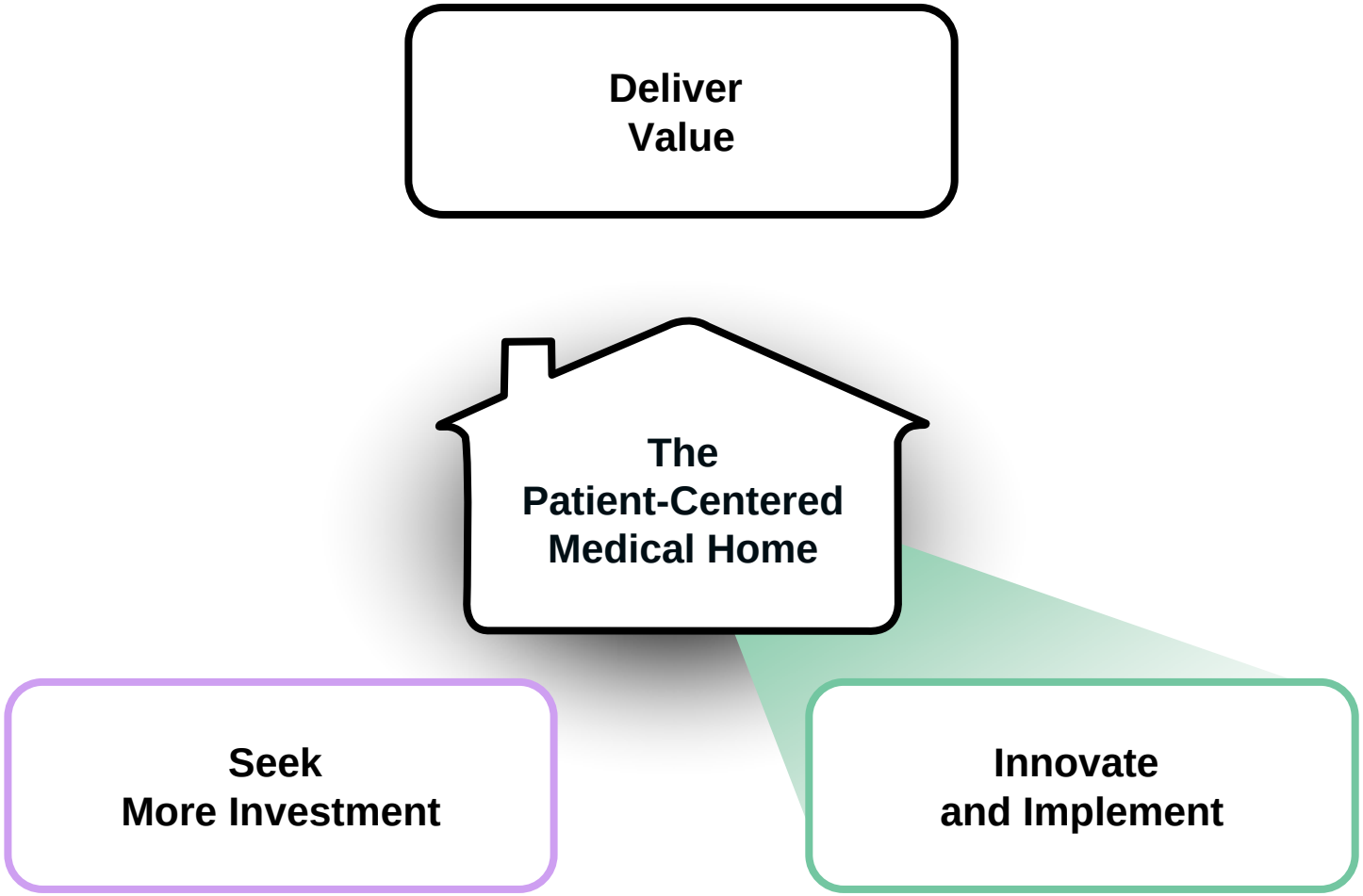
Source: Geisinger Health System, 2008.

Marillac's Integrated Care Patients (PCMH)



Future Outlook

Building the Business Case for Future Sustainability



How You Can Participate

1

Get involved in a pilot

2

Integrate PCMH health strategies

3

Engage consumers

Seeking The Ideal Payment Environment

- *Salary*- **problems with productivity**
- *Fee for service*- **problems with overuse**
- *Capitation*- **problems with under use**
- *Pay for performance*- **problems with ignoring the things not attached to payment**
-
- A ‘blended’ payment model is the answer for primary care and the PCMH!

The Patient-Centered Primary Care Collaborative recommends a three-part payment methodology,
Including:

A) A monthly care coordination payment for the physician's work that falls outside of a face-to face visit and for the health information technologies needed to achieve better outcomes,

B) A visit-based fee-for-service component that is recognized for services that are currently paid under the present fee-for-service payment system, and

C) A performance-based component that recognizes achievement of service, patient centeredness, quality and efficiency goals.

For more information, see www.pcpcc.net/content/proposed-hybridblended-reimbursement-model.

RUC recommendation to Medicare for the PCMH

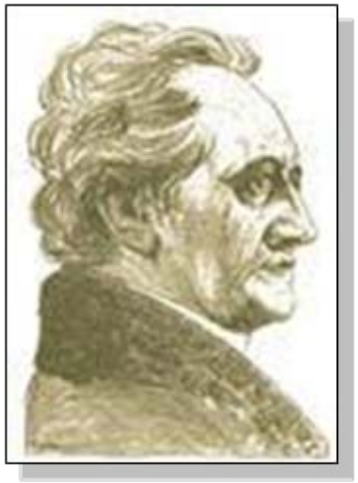
	Tier 1	Tier 2	Tier 3
Physician	$2,364	$2,837	$3,346
Case manager	$5,145	$6,965	$8,841
Professional liability insurance	$190	$190	$190
Electronic medical record	$0	$50	$1,015
Patient education booklet	$97	$97	$97
Month total	$7,796	$10,139	$13,489
Year total	$93,555	$121,671	$161,871

.

- There is a great deal of momentum for reshaping the payment environment around a primary care model
  - **"The Patient Centered Medical Home"**
- Good health policy that promotes personal and coordinated care for all will result in significant cost savings and better outcomes for patients and our population
- There is a major role for "population health improvement organizations" and active compliance management in this transition

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.**