Innovation in the Private Sector: The Patient Centered Medical Home

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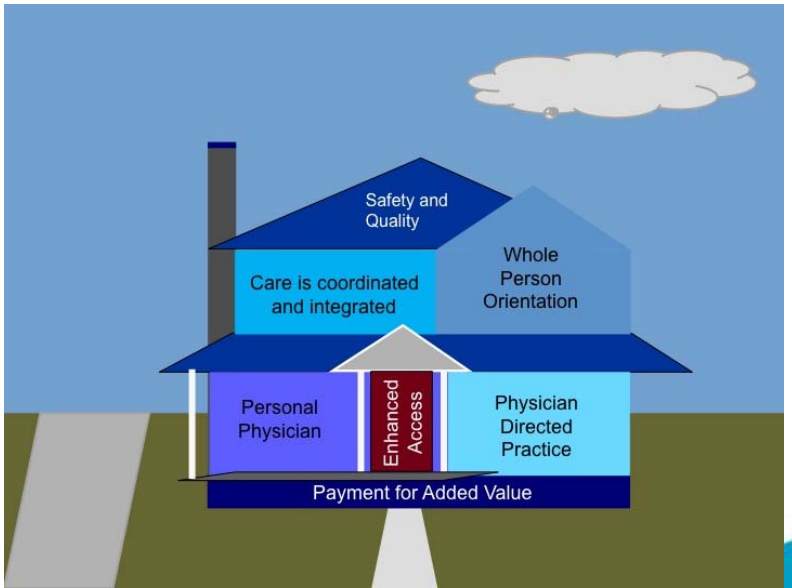
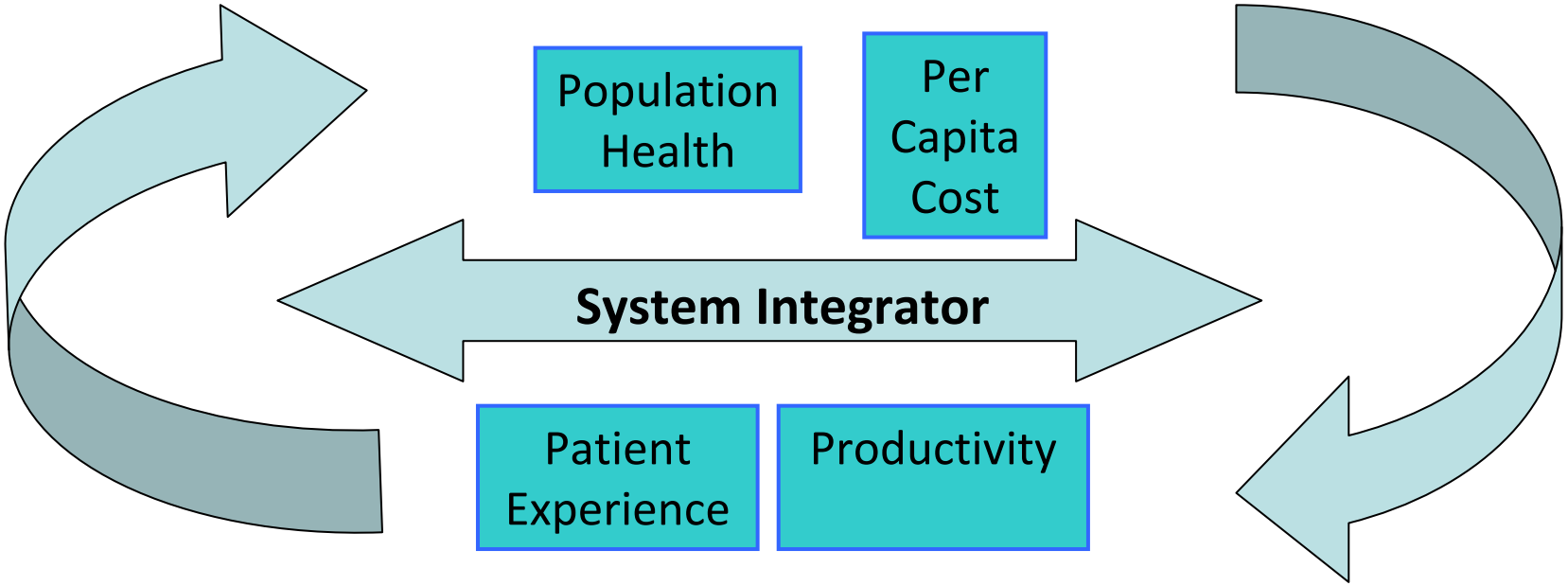
IBM‘s Director Healthcare Transformation

President Patient Centered Primary Care Collaborative

13th Population Health Colloquium and
Fifth National Medical Home Summit



Away from Episodes of Care to Management of the Population

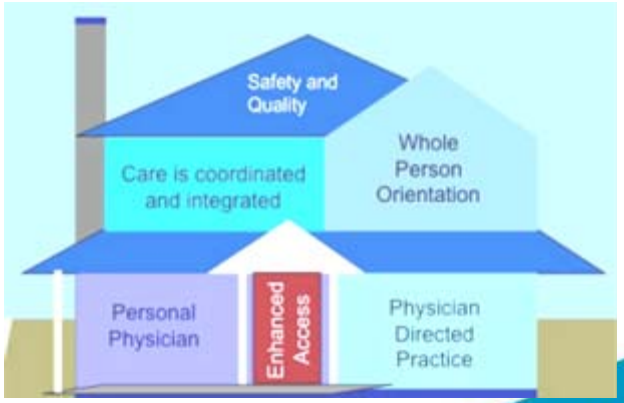


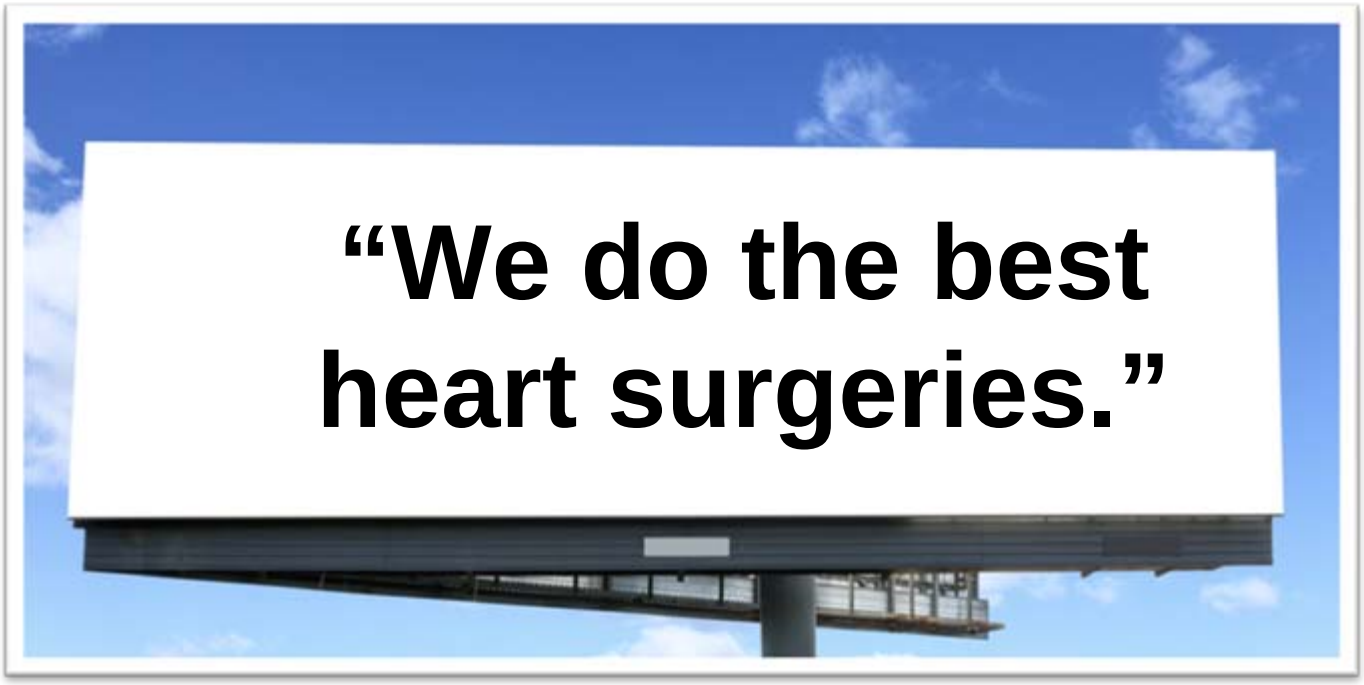
The System Integrator

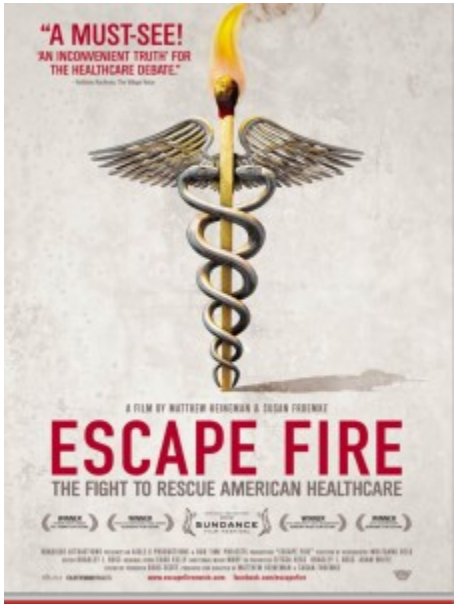
Creates a partnership across the medical neighborhood

Drives PCMH primary care redesign

Offers a utility for population health and financial management







“How to Stop Hospitals From Killing Us” *WSJ* – 7 March 2013

“Bitter pill: The cost of health care” - *Time* - 23 Feb 2013

Smarter Healthcare

36.3% Drop in hospital days

32.2% Drop in ER use

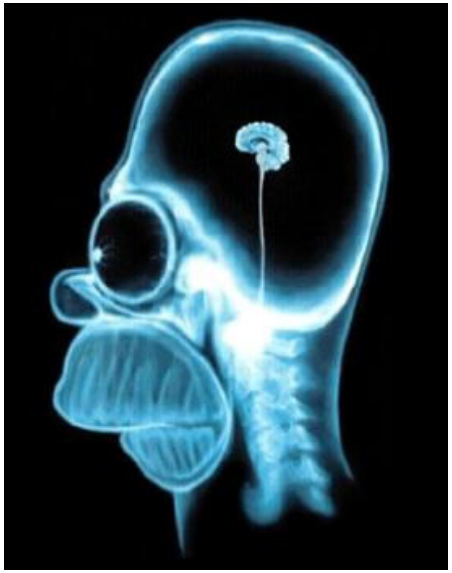
12.8% Increase Chronic Medication use

-15.6% Total cost

10.5% Inpatient specialty care costs down

18.9% Ancillary costs down

15.0% Outpatient specialty down



Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the US - PCPCC Oct 2012

WellPoint PCMH Preliminary Year 2 Highlights

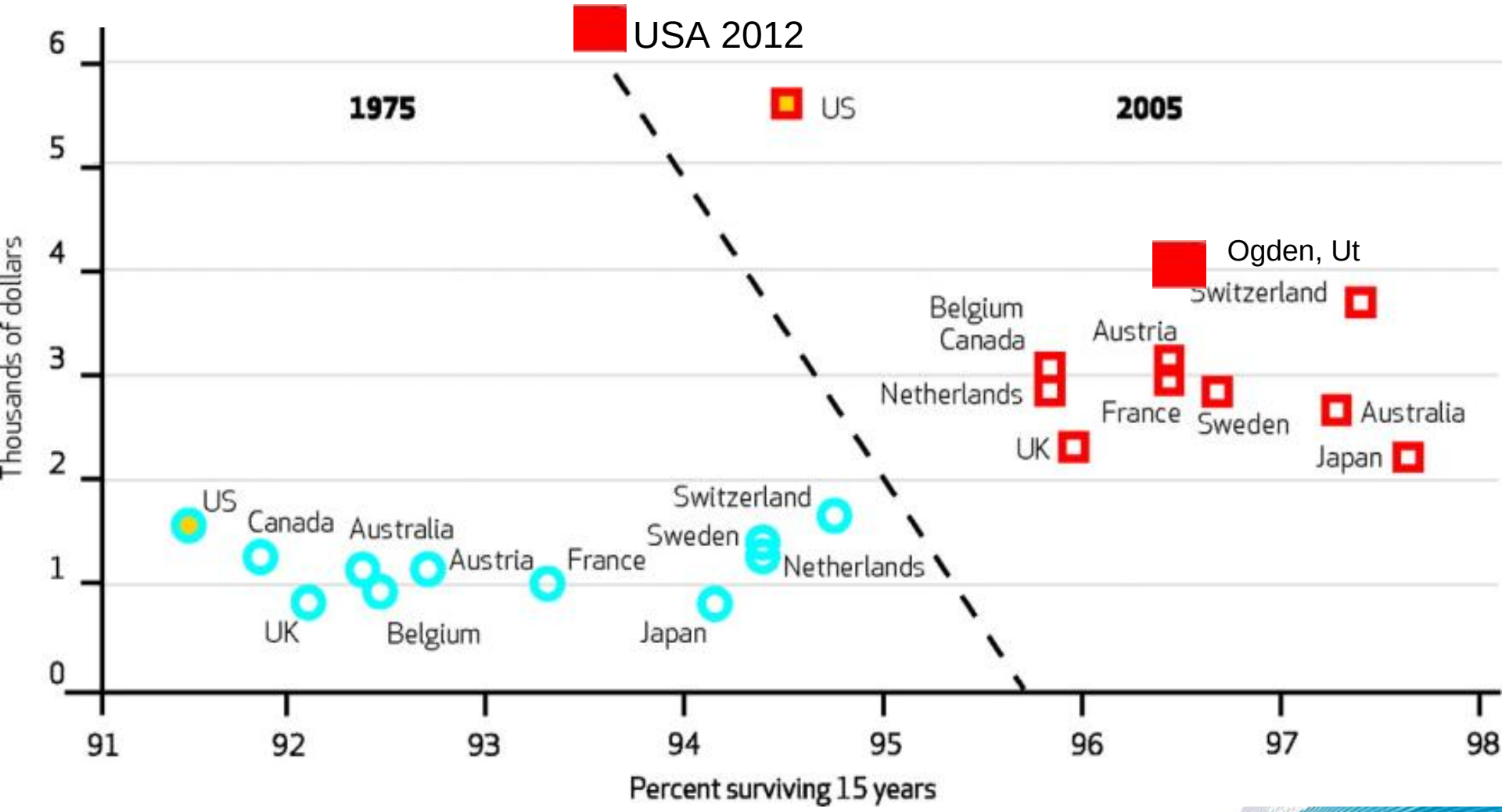
September 2012 Issue of *Health Affairs*

Colorado

NEW HAMPSHIRE

New York

- **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**


USA 2012
1975
US
2005
Ogden, Ut
Switzerland
Belgium
Canada
Austria
Netherlands
France
Sweden
Australia
UK
Japan
US
Canada
Australia
Austria
France
Switzerland
Sweden
Netherlands
UK
Belgium
Japan
Thousands of dollars
0
1
2
3
4
5
6
91
92
93
94
95
96
97
98
Percent surviving 15 years


POWER7
POWER7
POWER7
POWER7
POWER7

Practice Transformation away from Episode of Care

Master Builder

Preventive Medicine

Chronic Disease Monitoring

Medication Refills

Acute Care

Test Results

DOCTOR

Master Builder

Case Manager

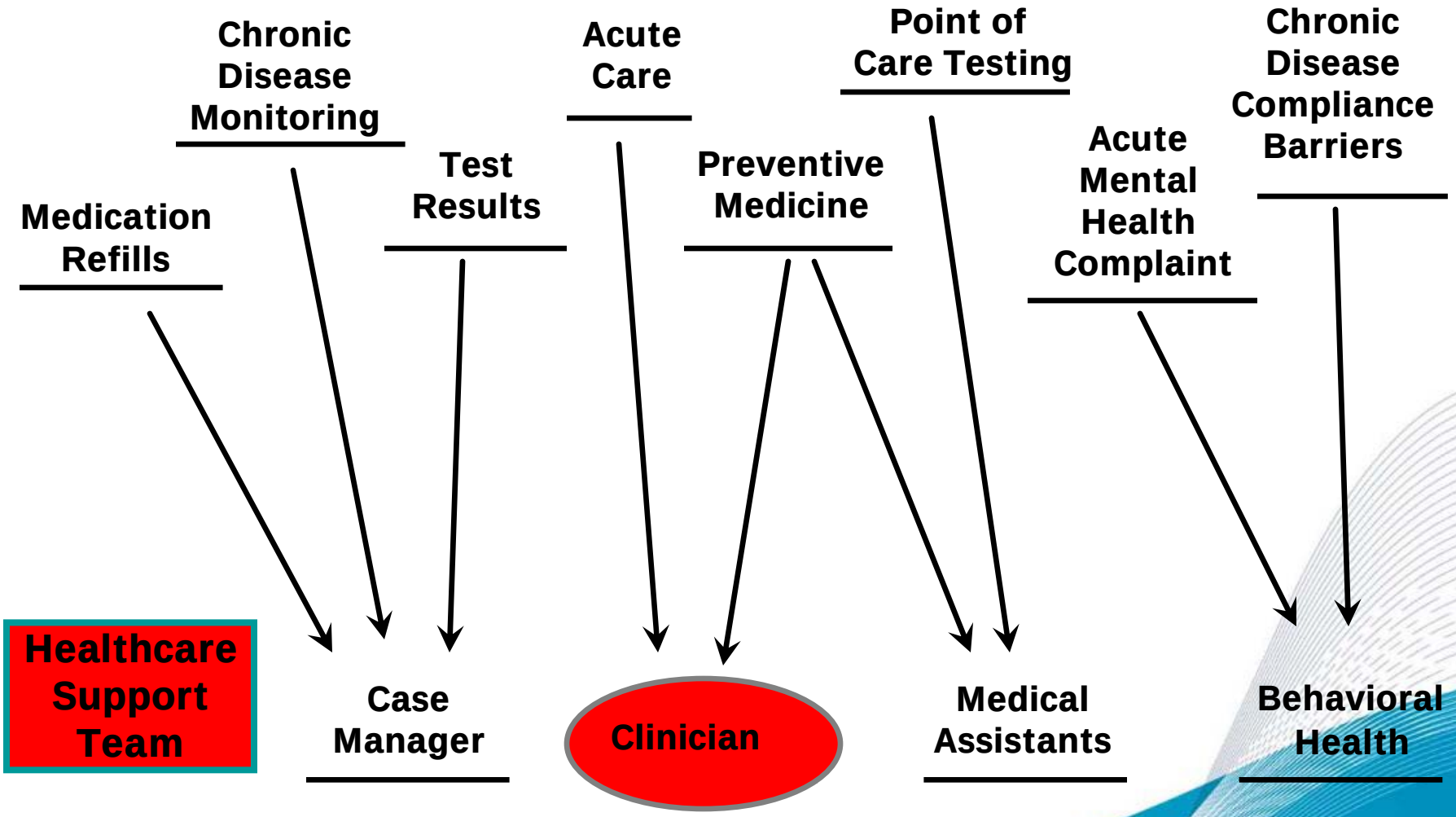
Behavioral Health

Medical Assistants

Nursing

Source: Southcentral Foundation, Anchorage AK

PCMH Parallel Team Flow Design
The Glue is Real Data, not a Doctor's Brain

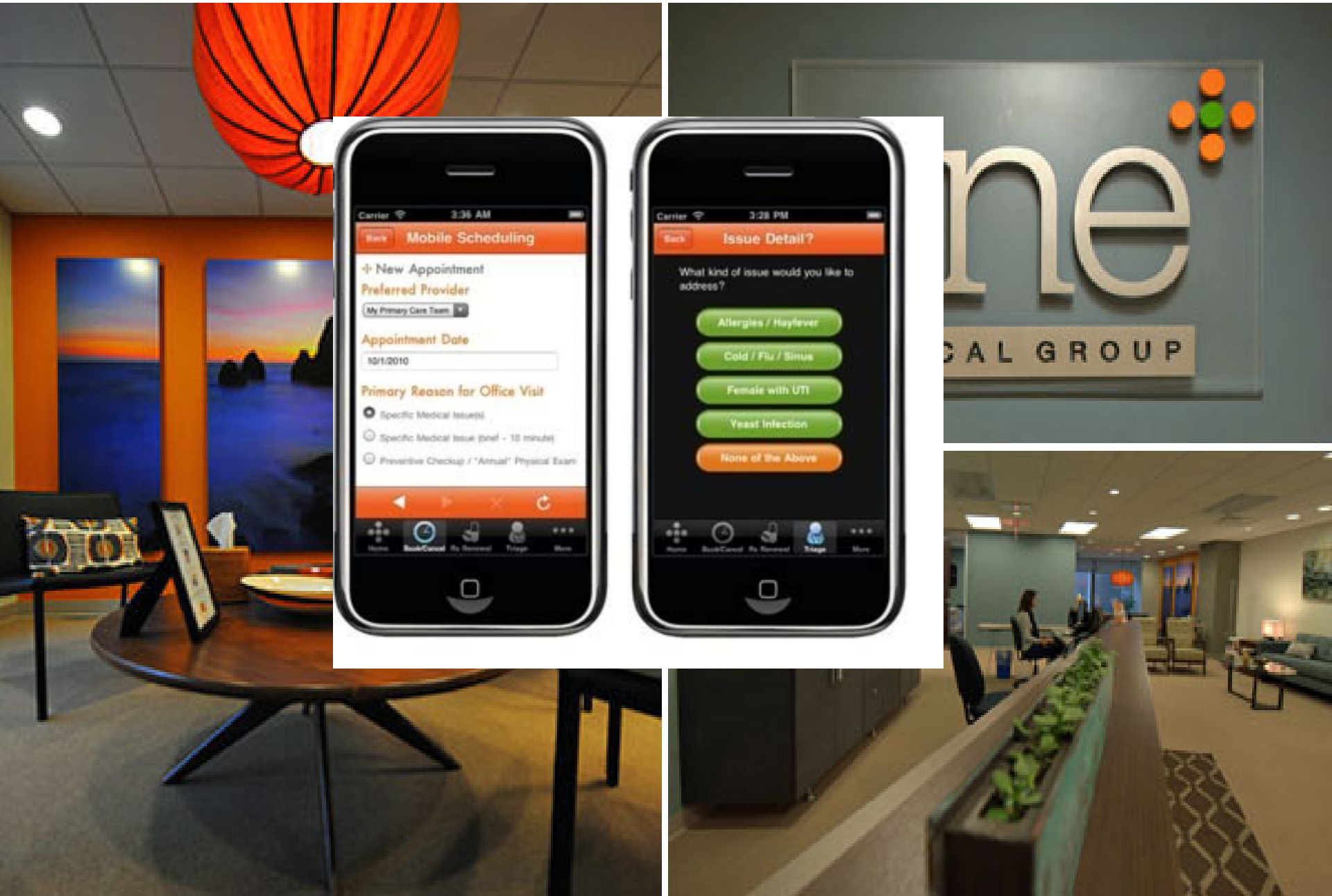


Source: Southcentral Foundation, Anchorage AK

Healthcare will Transform

- Data driven
- Every patient has a plan
- Team based

MobileFirst Patient Consumer

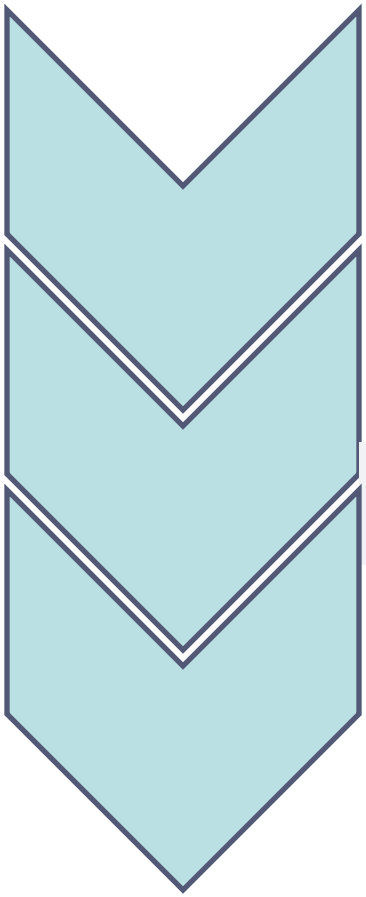


MobileFirst Remote Sensing

Mobile Sensing emotion for mental health status -- a*nalyzes 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 -- b*enefit design feedback*

Defining the Care Centered on the Patient

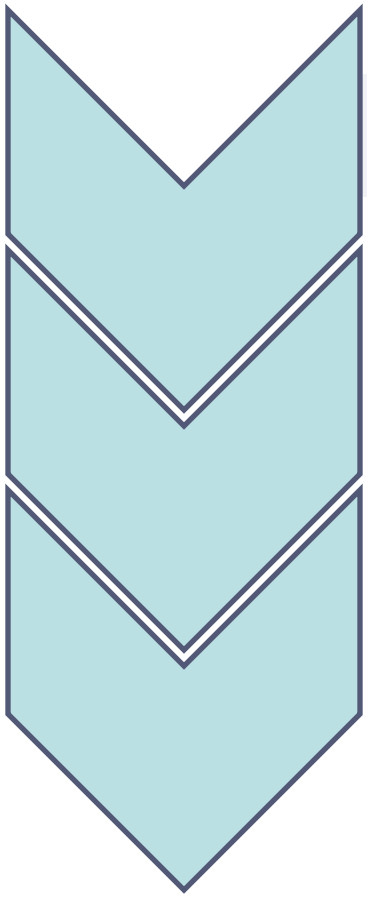


Superb Access to Care

Patient Engagement in Care

Clinical Information Systems, Registry

Care Coordination



Team Care

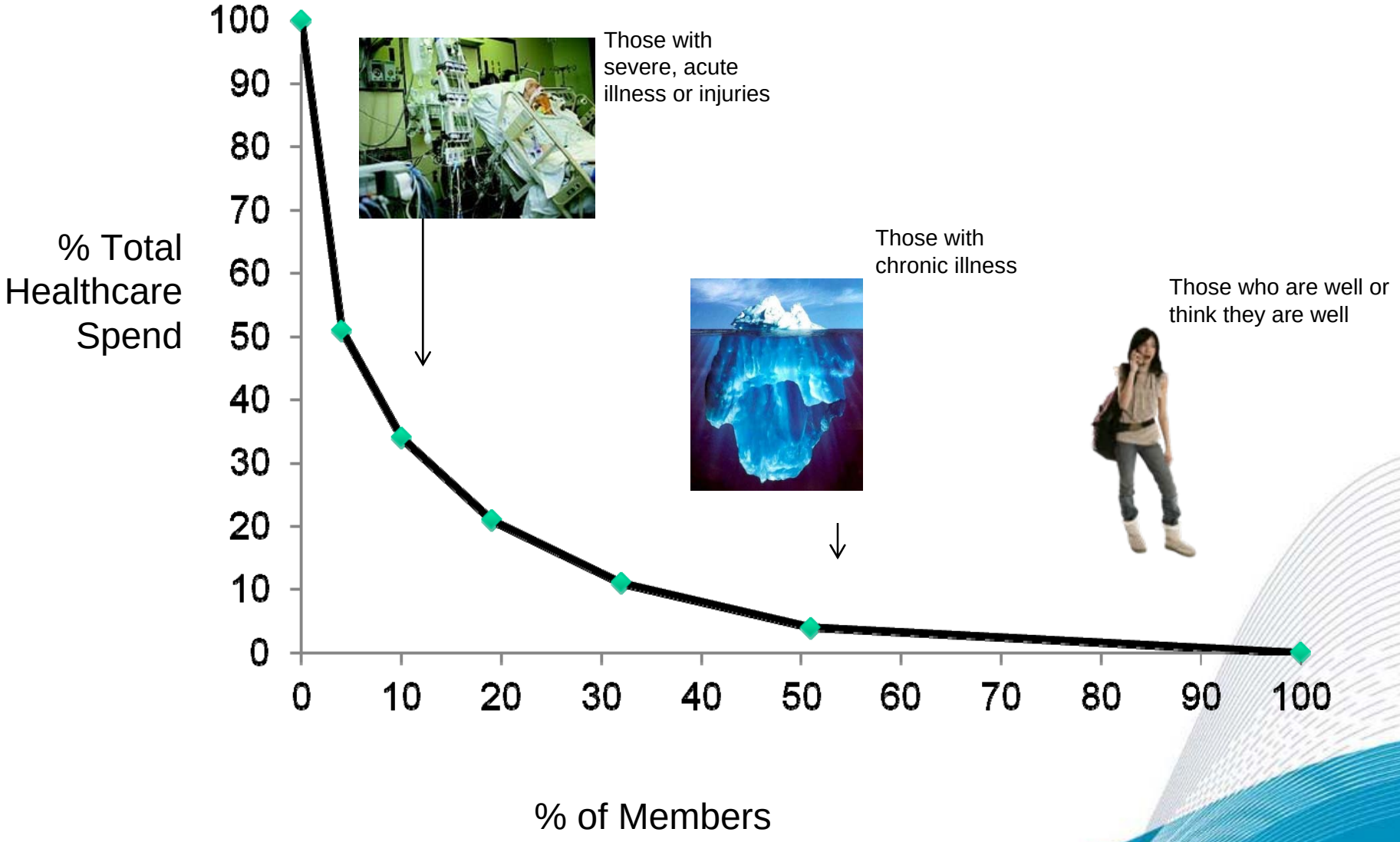
Communication Patient Feedback

Mobile easy to use and Available Information

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”

Benefit Redesign - Patient Engagement: Different Strategies for Different Healthcare Spend Segments



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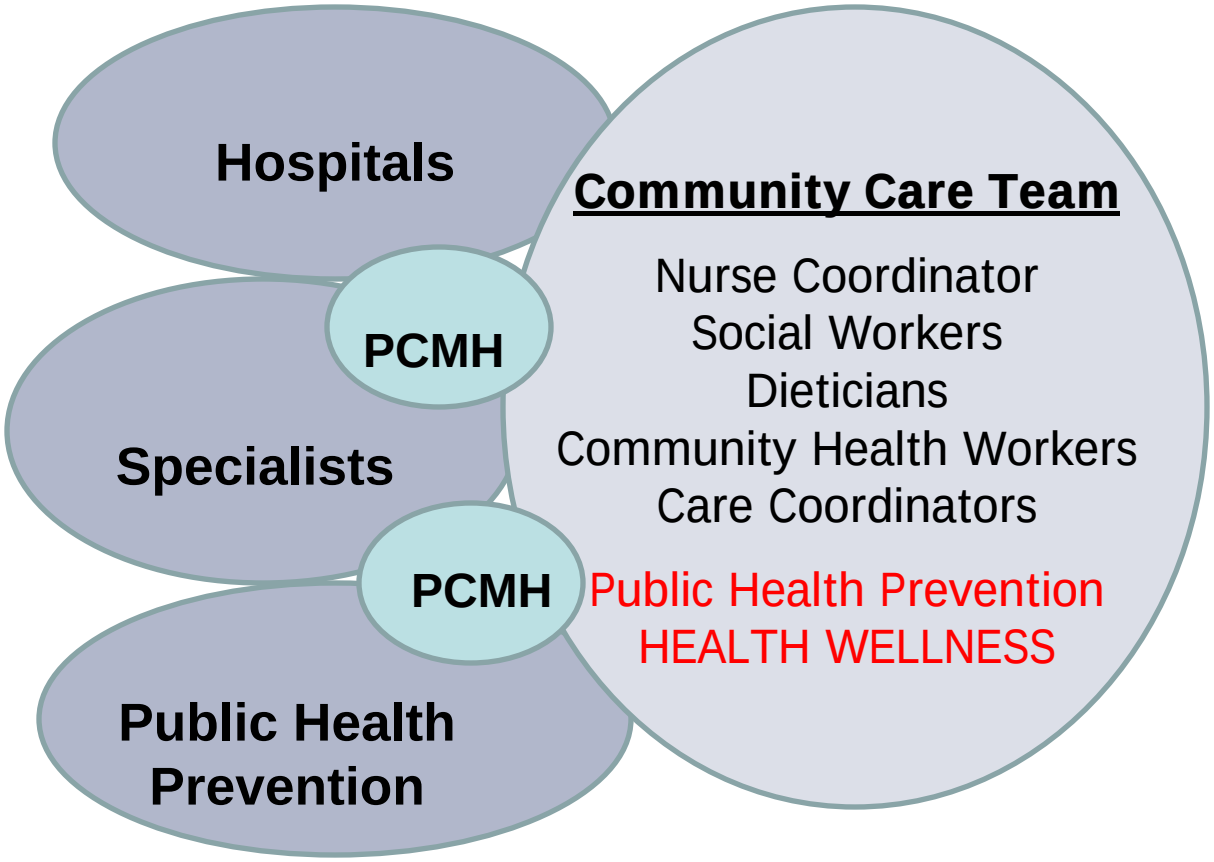
PCMH in Action



A Coordinated Health System

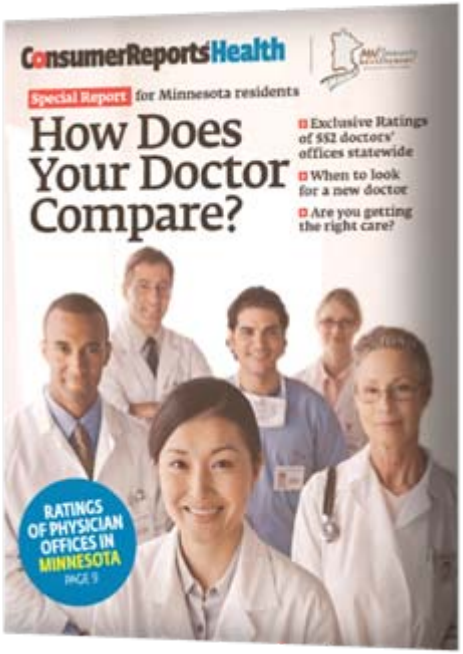
Health IT Framework

Global Information Framework

Evaluation Framework

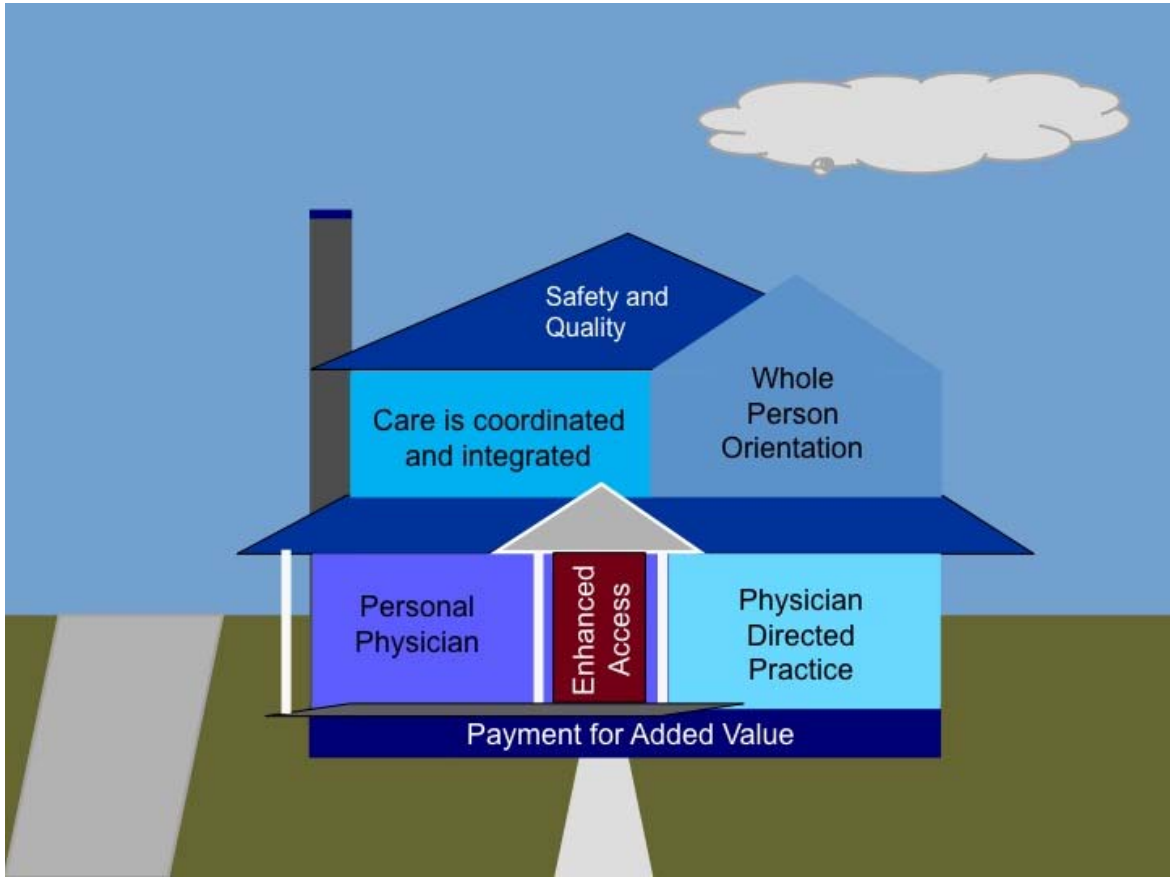
Operations

Patients not shortchanged

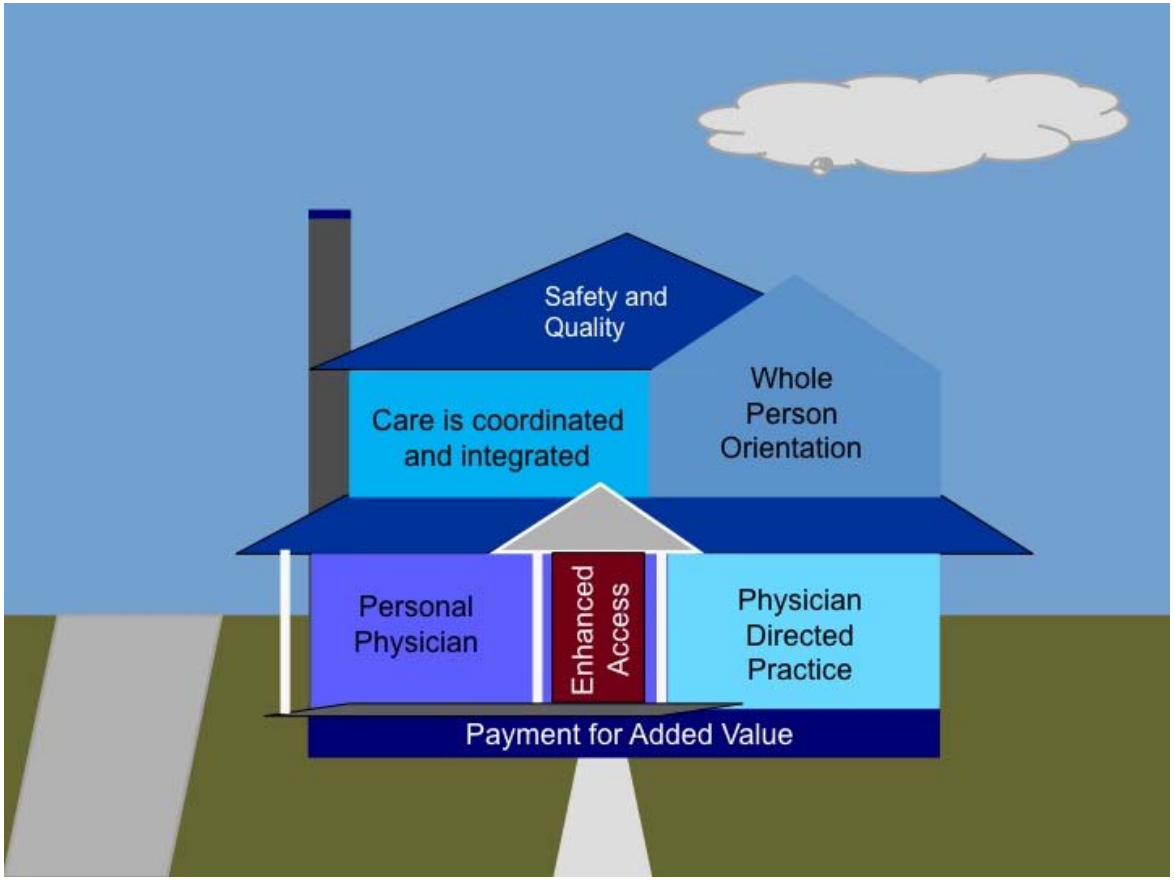


PCMH as the Foundation

The right care foundation
The right time
The right price



END


Safety and Quality
Care is coordinated and integrated
Whole Person Orientation
Personal Physician
Enhanced Access
Physician Directed Practice
Payment for Added Value

Patient-Centered Primary Care COLLABORATIVE

Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies
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
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
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
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.
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

Potential Impacts

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

↓

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

↓

Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions.