Patient-Centered Medical Home

Paul Grundy, MD, MPH, FACOEM, FACPM
IBM Director Healthcare Transformation
President Patient Centered Primary Care Collaborative
Patient Centered Medical Home/Neighborhood

Treat your Care Needs like a **BAD MEDICAL NEIGHBORHOOD!!** do not go there alone
belong to PCMH  !!
dangerous !!
Health Care Reform
The Flexner Report

"We have, indeed, in America, medical practitioners (medical communities) not inferior to the best elsewhere; but there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst."

Abraham Flexner 1910

94 out of 160 medical schools were closed
Change is coming – HIT is one of the currents

- The LAW well is the Law!! – it will require increase quality lower cost. As sure as gas prices will go up
- The GM / Kodak
- Could give you competitive advantage
- **Stop whining** and get on -- you will have to in some
How do you fix the foundational issue: our healthcare system is so High Cost and yet so low value??

Average health spend per capita ($US PPP)

The World Health Organizations ranks the U.S. as the 37th best overall healthcare system in the world.

Countries’ age-standardized death rates, list of conditions considered amenable to health care
Healthcare in US ranks last among developed countries: AGAIN June 2010 – How the world see us !! (comments by next to last ranked Canada)

“The **main determinant** of overall health-care system performance is the **quality of primary health care**.

Of course, **our health system does well when compared with the U.S.** But so do all other developed countries’

To have the USA beat us is It’s like winning Basketball against a bunch of “Little People”!!”
The HUB where information is action

- “The first step is getting more better primary care"
- “This issue of Primary care is absolutely critical it has the potential of making such a big difference for the quality of health for everyone… how do we give **Primary care** the power to be the HUB around **PATIENT** Centered Care
- June 16th 2010 $250 Million Primary care Training
- DOD today 1.8 Billion PCMH transformation
- VA 3.8 Billion PCMH transformation

Patient Centered Medical Home
The HUB

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...
The Trusted Clinician Can be a Powerful Influence

![Diagram showing the rating of relationships]

Source: Magee, J., Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. 2003
“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)
from “Healthcare Reform Now
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.”

George Halverson, from “Healthcare Reform Now
Diabetes acute complications admission rates, population aged 15 and over, 2007

1. Does not fully exclude day cases.
2. Includes transfers from other hospital units, which marginally elevates rates.

*Source: OECD Health Care Quality Indicators Data 2009 (OECD).*
After-Hours Care that is linked to your own Doctor

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
The Joint principles Patient Centered Medical Home

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, and continuous and comprehensive care

- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients

- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or arranging care with other qualified professionals

- **Care is coordinated and integrated across all elements of the complex healthcare community** - coordination is enabled by registries, information technology, and health information exchanges

- **Quality and safety are hallmarks of the medical home** - Evidence-based medicine and clinical decision-support tools guide decision-making; Physicians in the practice accept accountability voluntary engagement in performance measurement and improvement

  **Enhanced access to care is available** - systems such as open scheduling, expanded hours, and new communication paths between patients, their personal physician, and practice staff are used

- **Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home** - providers and employers work together to achieve payment reform
The Patient Centered Primary Care Collaborative: Examples of broad stakeholder support and participation

Providers
333,000 primary care
- ACP
- AAFP
- AOA
- ABIM
- ACOI
- AHI

Purchasers –
Most of the Fortune 500
- IBM
- General Motors
- FedEx
- General Electric
- Pfizer
- Merck
- Business Coalitions
- Wal-Mart

80 Million lives

Payers
- BCBSA
- United
- CIGNA
- WellPoint
- Kaiser
- Aetna
- Humana
- HCSC
- MVP

Patients
- NCQA
- AFL-CIO
- National Partnership for Women and Families
- Foundation for Informed Decision Making
- SEIU
Defining the Medical Home

Superb Access to Care
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.

Patient Engagement in Care
- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Clinical Information Systems
- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

Care Coordination
- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Team Care
- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Patient Feedback
- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

Publicly available information
- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.
Geisinger Health System

**Geisinger Medical Home Sites and Hospital Admissions**

<table>
<thead>
<tr>
<th>Hospital admissions per 1,000 Medicare patients</th>
<th>Medical Home</th>
<th>Non-Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CY 2007</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lewisburg Penn</th>
<th>Pre-Test period Jan - Oct 2006</th>
<th>First pilot year Jan – Oct 2007</th>
<th>Percent reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission</td>
<td>365/1000</td>
<td>291/1000</td>
<td>- 20%</td>
</tr>
<tr>
<td>Hospital re-admissions</td>
<td>15.2%</td>
<td>7.9%</td>
<td>- 48%</td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td></td>
<td>9% less</td>
</tr>
</tbody>
</table>

Source: Geisinger Health System, 2008.
Vermont Financial Impact

### Percentage of Vermont population participating

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.7%</td>
<td>9.8%</td>
<td>13.0%</td>
<td>20.0%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

### Participating population

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42,179</td>
<td>61,880</td>
<td>82,332</td>
<td>127,045</td>
<td>254,852</td>
</tr>
</tbody>
</table>

### # Community Care Teams

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>
# The Results
## A Summary of Medical Home Pilot Successes

<table>
<thead>
<tr>
<th>Medical Home Demonstration and Pilot Project</th>
<th>ER Care Utilization</th>
<th>Hospital Care Utilization</th>
<th>Specialist Care Utilization</th>
<th>Overall Costs Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Cooperative of Puget Sound¹</td>
<td>29%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Care of North Carolina¹</td>
<td>16%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HealthPartners Medical Group¹</td>
<td>39%</td>
<td>24%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gesinger Health System¹</td>
<td>-</td>
<td>14%</td>
<td>-</td>
<td>9%</td>
</tr>
<tr>
<td>Genesee Health Plan¹</td>
<td>50%</td>
<td>15%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Colorado Medicaid and SCHIP¹</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>22%</td>
</tr>
<tr>
<td>Intermountain Healthcare Medical Group¹</td>
<td>-</td>
<td>10%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Johns Hopkins¹</td>
<td>15%</td>
<td>24%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MDVIP (concierge medical practices)²</td>
<td>50%</td>
<td>50%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Boeing Company³</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20%</td>
</tr>
<tr>
<td>Urban Medical Group⁴</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20%</td>
</tr>
<tr>
<td>Leon Medical Centers⁴</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20%</td>
</tr>
<tr>
<td>Caremore Medical Group⁴</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td>Redlands Family Practice⁴</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Average Utilization Reduction / Savings</strong></td>
<td><strong>30%</strong></td>
<td><strong>25%</strong></td>
<td>?</td>
<td><strong>17%</strong></td>
</tr>
</tbody>
</table>

All the pilots listed above were implemented within a fee-for-service payment system - one that rewards doctors for doing more.

¹ Patient-Centered Primary Care Collaborative, Proof in Practice, A compilation of patient centered medical home pilot and demonstration projects, 2009
² MDVIP, Hospitalization rates compared to top performing health plans by state, 2005
³ Health Affairs, Are Higher-value Care Models Replicable?, Arnold Milstein and Pranany P. Kothari, October 29, 2009
⁴ Health Affairs, American Medical Home Runs, Arnold Milstein and Elizabeth Gilbertson, October 2009
⁵ Qliance Medical Group, (non-scientific) clinician survey, 2010
Group Health’s decision to adopt the medical home model “looks brilliant,””

- not just for patient care but in terms of business.
- Group Health added 35,000 net new members in 2009 and had already added 14,000 net new members in January 2010 alone.
- Then there is the $40 million a year in total cost savings projected from moving to the medical home model.
- Armstrong predicts, Group Health will end up with a significant cost advantage over rival insurers in the Washington and Oregon markets.
- Armstrong says, Group Health 10 percent per member per month cost advantage for commercial customers.
- Group Health is aiming for a 15 percent cost edge in the future.
- That would translate into lower premiums or richer benefits, or both, for members.
- Now that they’ve moved to the medical home, most Group Health doctors like the new digs and don’t want to go back. “
Payment requires more than one method
It is not rocket science you have dials, adjust them !!!

“fee for health,”
“fee for outcome,”
“fee for process,”
“fee for belonging/membership”
“fee for service”
Fee for satisfaction
We are Beyond the Pilot

Independence BCBS PA implemented a new PCMH reimbursement system
10% bump in base pay Primary Care
$1.25 for Level 1
$2.00 for Level 2
$3.00 PMPM for Level 3
Doubling of the P4P dollars Quality and Cost of Care within the control of the PCP
IBM Announces FREE Primary care to its employees

Give Employees 100% Coverage for Primary Care

This is part of our partnership with Primary care in our journey together for better healthcare

Advanced primary care means one-third less cost for and 19% lower mortality for our employees
Types of Change

Developmental
- Learn new skills
- Implement new policies
- Physician centric

Transitional
- Process change
- Team building
- Physician centric

Transformational
- Behavior and culture shift
- New paradigm
- Patient centric

R. Scott Hammond, M.D., Primary Care Consultants, Inc.
Patient Centered Medical Home technology ...

- **Advanced analytics and clinical decision support** at the point of care are the bricks and mortar of the medical home

- **Compliance with ARRA “Meaningful Use”, NCQA, PQRI** and population specific metrics ensure optimal quality outcomes and maximize reimbursement models

- **Clinical Integration** – means value for the patients, the physician practice, and the payers

- **Remote hosting** means low upfront investment to jumpstart “care delivery transformation” and offers affordable “industrial strength” healthcare platforms
Primary Care Providers need a “on ramp” for PCMH (the HUB)

- Smarter clinical content that supports NCQA requirements
- Powerful reporting analytics and automated alerts, reminders and exception lists
- Evidence-based personalized health with ease of ability to incorporate into practice
- Integration automation that allows correct and complete diagnosis
- Low capital start up costs, and minimal ongoing IT maintenance and investments
A journey to higher quality lower cost
quality as well as efficiency
MISSISSIPPI PATIENT-CENTERED MEDICAL HOME ACT

HOUSE BILL NO. 1192
TO DIRECT THE STATE BOARD OF HEALTH TO ADOPT THE PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

- Care in a patient-centered medical home is coordinated across all elements of the health care system and the patient’s community to assure that the patient receives the indicated care when and where the patient needs the care in a culturally appropriate manner;
- A patient in a patient-centered medical home actively participates in health care decision making, and feedback from the patient is sought to ensure that the expectations of the patient are being met;
- Patient programs that provide a whole-person orientation that includes care for all stages of life, including acute care, chronic care, disability care, preventive services and end-of-life care;
Moving towards a more coordinated system

Cooperating in new efforts to better coordinate care
- Accountable Care Organizations (ACO’s)
- Community health teams
- HIT

Working with innovative reimbursement structures
- Bundled payments
- Expanded pay-for-Quality
- Readmission incentives
- Outlier reductions

Patient Centered Medical Homes

Improving health outcomes
- Prevention (primary and secondary)
- Chronic disease management
- Patient engagement and education
- Data transparency
MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Policy Memorandum: Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs

References: (a) Assistant Secretary of Defense (Health Affairs) (ASD (HA)) Policy 99-033, Individual Assignments to Primary Care Managers by Name. (http://mhs.osd.mil/content/doc/pdfs/policies/1999-033.pdf)
(b) ASD(HA) Policy 06-007 TRICARE Policy: 2006 Standard Area Standards (http://mhs.osd.mil/d皇上司fas/200608-007.pdf)
(c) ASD (HA) Policy 07-009 Access to Primary Care (http://mhs.osd.mil/d皇上司fas/200707-009.pdf)

This policy, in conjunction with references (b) and (c), is hereby cancelled. References (b) and (c) outline the current standards for timely access to appointments. The current standards ensure timely access to appointments. The policy builds on MTF current success with appointment access and provider continuity by requiring that a single primary care framework be adopted that specifically targets communication and patient-centered health care delivery.

The Patient-Centered Medical Home (PCMH) is an established model of primary care that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication. Consistent with longstanding MHS goals, the PCMH is associated with better clinical outcomes, patient satisfaction, and reduced costs. The principles of the PCMH is that patients see the same care provider who delivers first contact care, and to utilize innovative approaches that are patient-centered and access focused. Open access scheduling, online appointing and online provider/patient communication, 24-hour nurse advice and triage lines, and provider/patient telephonic consults are examples of some innovative approaches that may used to enhance patient provider communication.

The effectiveness of PCMH policy implementation will be assessed through PCM assignment and PCM team appointment continuity. Measures of the effectiveness of PCMH outcomes will be assessed through MHS measures of access, and through measures of patient satisfaction with care, patient satisfaction with provider communication, and patient satisfaction with technical health care quality. Metrics will be reported to leaders through the MHS Strategic plan, with MHS action plans and incentive programs to reward innovation and success developed through the MHS Clinical Quality Forum, the Clinical Prognostic Steering Committee, and the Senior Military Medical Advisory Committee.

A centrally supported PCMH communication plan will be developed to meet the standards for meeting the PCMH model. The MHS PCC Policy Committee will monitor the status of the PCMH policy and support the development of the MHS Clinical Quality Forum. The panel will be assisted in this activity by the Tricare Management Activity.

cc: Service Surgeons General

In the VA and DOD Every patient is assigned a Patient Centered Medical Home and Primary Care Manager (PCM)

This policy is applicable to all MTFs and is effective immediately
Under the new Law The Secretary of Health and Human Services (HHS) will have the authority to expand pilot programs and put them into practice—without going through Congress. (See the law, Patient Protection and Affordable Care Act, § 3021 (2009), Center for Medicare and Medicaid Innovation within CMS, p.723).
On June 2nd 2010 HHS Secretary Sebelius, announced the rollout the Centers for Medicare and Medicaid Services (CMS) will establish a demonstration program that will enable Medicare to join Medicaid and private insurers in innovative state-based advanced primary care initiatives.

**New Medicare Demonstration**

• Design will include mechanisms to assure it generates savings for the Medicare trust funds and the federal government

• Private insurers work in cooperation with Medicaid to set uniform standards for “Advanced Primary Care (APC) models”

• Provide incentives for doctors to spend more time with their patients and offer better coordinated higher-quality medical care

**States Wishing to Participate in the New Demonstration Must:**

• Certify they have already established similar cooperative agreements between private payer and their Medicaid program;

• Demonstrate a commitment from a majority of their primary care doctors to join the program;

• Meet a stringent set of qualifications for doctors who participate; and

• Integrate public health services to emphasize wellness and prevention strategies.
The PCMH model impacts stakeholders across the continuum of care

**Payer:** Improved member and employer satisfaction, lower costs, opportunity for new business models

**Hospital:** Lower number of admissions and re-admissions for chronic disease patients; able to focus on procedures.

**Primary Care Provider:** Increased focus on the patient and their health, greater access to health information; higher reimbursement; more PCPs

**Patient:** Better, safer, less costly, more convenient care and better overall health, productive long-term relationship with a PCP

**Specialists:** Better referrals, more integrated into whole patient care, better follow up less re-hospitalizations

**Government:** Lower healthcare costs, healthier population

**Employer:** Lower healthcare costs, more productive workforce, improved employee satisfaction

**Pharma:** Improved communication platforms and relationships with healthcare providers, patients and payers; increased sales through improved patient identification, diagnosis, and treatment; recognized as a key player in the patient health delivery value chain
Benefits of Patient Centered Medical Home

Patients
- Reduce hospital
- Better care
- Better satisfaction
- Improved health status

Payers
- Flexible provider payments
- Collaborative Provider relationship
- Reduce overall medical spend

Hospitals
- Reduce readmission
- Reduce inappropriate use of ED
- Improve discharge planning

Doctors
- Improved PCP’s reimbursement
- Practice efficiency
- Patient satisfaction
The Stalemate that blocks change

Comprehensive providers unable to transform practice without viable & sustainable payment for desired services

Employers & payers unwilling to pay for desired services unless primary care demonstrates value AND creates potential to save money

Slide courtesy of Lisa M. Letourneau MD, MPH – Maine PCMH
Patient Centered Primary Care Collaborative
“Proof in Practice– A Compilation of Patient Centered Medical Home Pilot and Demonstration Projects” Released October 2009

- Developed by the PCPCC Center for Multi-stakeholder Demonstration through a grant from AAFP offering a state-by-state sample of key pilot initiatives.
- Offers key contacts, project status, participating practices and market scan of covered lives; physicians.
- Inventory of: recognition program used, practice support (technology), project evaluation, and key resources.
- Begins to establish framework for program evaluation/ market tracking.
Why employers care about PCMH

- Improved coordination of healthcare
- Enhanced quality of care
- Better clinical outcomes
- Improved patient satisfaction with healthcare
- And (hopefully) lower health and lost productivity costs
  - Healthier workforce
  - Healthier families in workforce
  - Increased efficiency of care (reduces costs)
  - More valuable health benefit
Patient Centered Primary Care Collaborative
“Purchaser Guide” Released July, 2008

- Developed by the PCPCC Center for Benefit Redesign and Implementation
- Guide offers employers and buyers actionable steps as they work with health plans in local markets - over 6000 copies downloaded and/or distributed.
- Includes contract language, RFP language and overview of national pilots.
- Includes steps employers can take to involve themselves now in local market efforts.
Patient Centered Primary Care Collaborative
“A Collaborative Partnership – Resources to Help Consumers Thrive in the Medical Home” Released October 2009

Included in the Guide:
- PCPCC activities and initiatives supporting consumer engagement
- Tools for consumers and other stakeholders to assist with PCMH education, engagement and partnerships
- A catalogue of resources with descriptions of and the means to obtain potential resources for consumers, providers and purchasers seeking to better engage consumers
Resources

- Patient-Centered Primary Care Collaborative: [http://pcpcc.net/content/patient-centered-medical-home](http://pcpcc.net/content/patient-centered-medical-home)
- PRISM: [http://www.prism1.org](http://www.prism1.org)
- American College of Physicians: [www.acponline.org/advocacy/where_we_stand/medical_home](http://www.acponline.org/advocacy/where_we_stand/medical_home)
- TransforMED: [http://www.transformed.com/transformed.cfm](http://www.transformed.com/transformed.cfm)
- MedHomeInfo: [www.medhomeinfo.org](http://www.medhomeinfo.org)
Questions?

- **Contact info:**
  Paul Grundy, MD
  pgrundy@us.ibm.com
  202-724-3331
Payment for Added Value

Safety and Quality

Care is coordinated and integrated

Whole Person Orientation

Personal Physician

Enhanced Access

Physician Directed Practice

Payment for Added Value
Whether building a community-wide ACO or a solo primary care practice, adherence to guiding PRINCIPLES provides the foundation. Through the PCMH Joint Principles, we (the buyers and providers) have agreed to change our covenant with one another. The Joint Principles of the PCMH have been agreed on by the entire "House of Medicine." They are therefore owned by the very folks that should deliver comprehensive care (the primary care providers) and their specialist colleagues. For Accountable Care to achieve its goals, successful organizations will NEED a foundation in these principles.

As a buyer, I want to be assured that the foundation - the principles - are in place, including a personal relationship with a healer, improved access, care that is coordinated, integrated, and comprehensive.
**Why you need to stop whining and move**

- Starting in 2015, hospitals with poor quality metrics could be financially penalized by Medicare and Medicaid. For example, a 300-bed hospital in the low-performing category could be penalized more than $1.3M annually. Each year, about 1,000 hospitals will fall into the bottom performance quartile, subjecting them to financial penalties. (THERE IS Teeth)

- Providers will need to improve quality substantially as government healthcare programs shift from fee-for-service to value-based reimbursement. (There is an Acton Plan)

- As Medicaid expands by 40% over the next decade, hospitals must learn how to operate on Medicaid rates, which currently do not fully cover hospitals' costs.

- Providers and payers should "unlock data" and share infrastructure to more effectively manage care (e.g., by creating accountable care organizations). **WORK TOGETHER**