



Building a Patient Centered Medical Home for our Armed Services

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Patient Centered
PRIMARY CARE
Collaborative

IBM Announces FREE Primary care to its employees

- ▶ IBM to Give Employees 100% Coverage for Primary Care
- ▶ This is part of IBM's partnership with Primary care in our **journey together** for better healthcare
- ▶ Advanced primary care means one-third less cost for IBM and 19% lower mortality for our employees
- ▶ IBM and Primary care together changing the covenant---how we pay

Policy Memorandum: Implementation of the Patient Centered Medical Home Model of Primary Care

Sept 18 2009



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

SEP 18 2009

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&PA)
ASSISTANT SECRETARY OF THE NAVY
ASSISTANT SECRETARY OF THE AIR FORCE

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/docs/pdfs/policies/1999/99-033.pdf>)
(b) ASD(HA) Policy 06-007 TRICARE Policy for Access to Care and Prime Standard Area Standards (<http://mhs.osd.mil/Content/docs/pdfs/policies/2006/06-007.pdf>)
(c) ASD (HA) Policy 07-009 Access to Primary Care Managers at Military Treatment Facilities (<http://mhs.osd.mil/Content/docs/pdfs/policies/2007/07-009.pdf>)

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 be 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 access, and through patient-centered care quality. Metrics will include MHS action plans and implementation through the MHS Management Committee, and the Senior Military Medical Advisory Committee.

A centrally supported PCMH communication plan will be developed to meet Service-specific requirements for educating and reinforcing the PCMH model. The MHS communications plan will target both TRICARE Prime beneficiaries and MTF personnel.

My point of contact for this policy is Colonel John P. Kugler, Deputy Chief Medical Officer, Office of the Chief Medical Officer, TRICARE Management Activity. He can be reached at (703)681-0071 or at John.Kugler@tma.osd.mil.

This policy is applicable to all primary care settings and all MTFs and is effective immediately

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 outcomes, reduced mortality, fewer hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care and reduced medical spending. One of the core principles of the PCMH is the care provider who delivers first

The effectiveness of PCMH Policy will be assessed through PCM assignment and PCM team appointment continuity

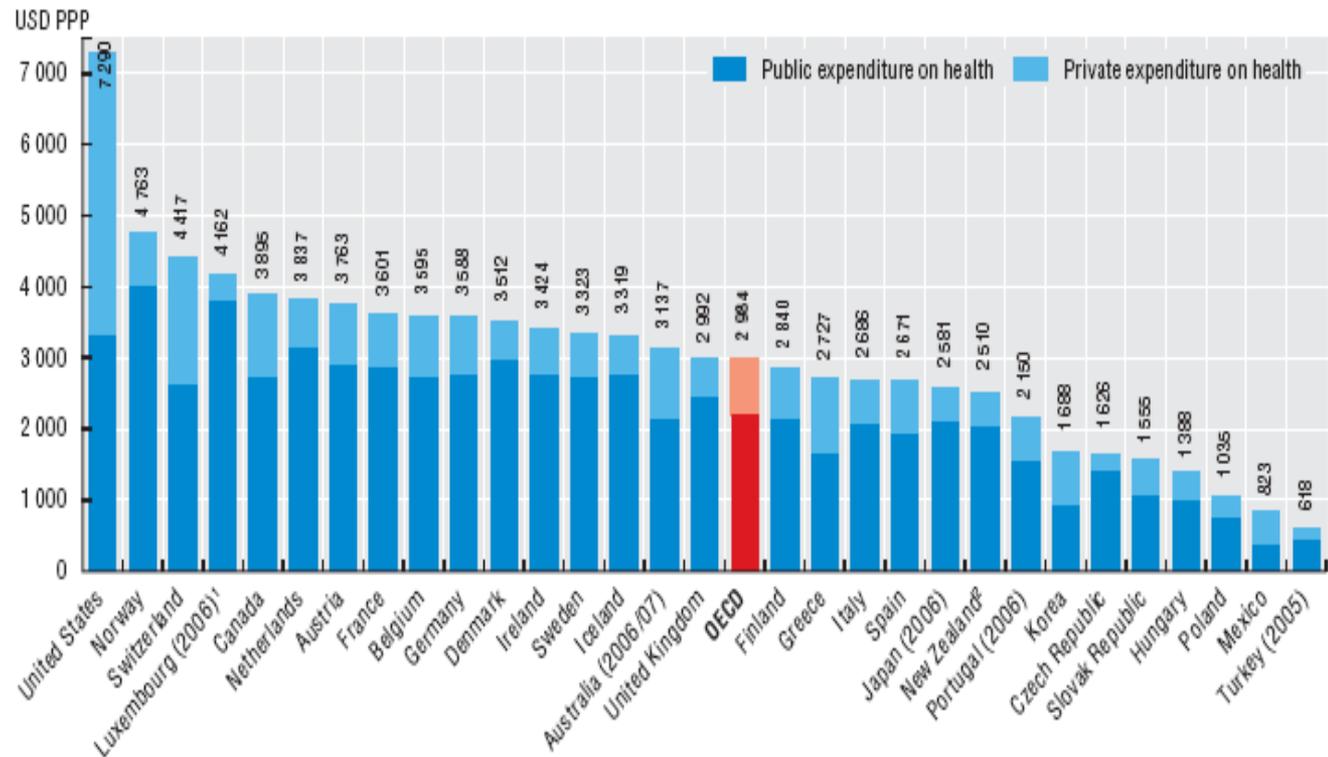
Ellen P. Embrey
Deputy Assistant Secretary of Defense
(Force Health Protection and Readiness)
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

cc:
Service Surgeons General

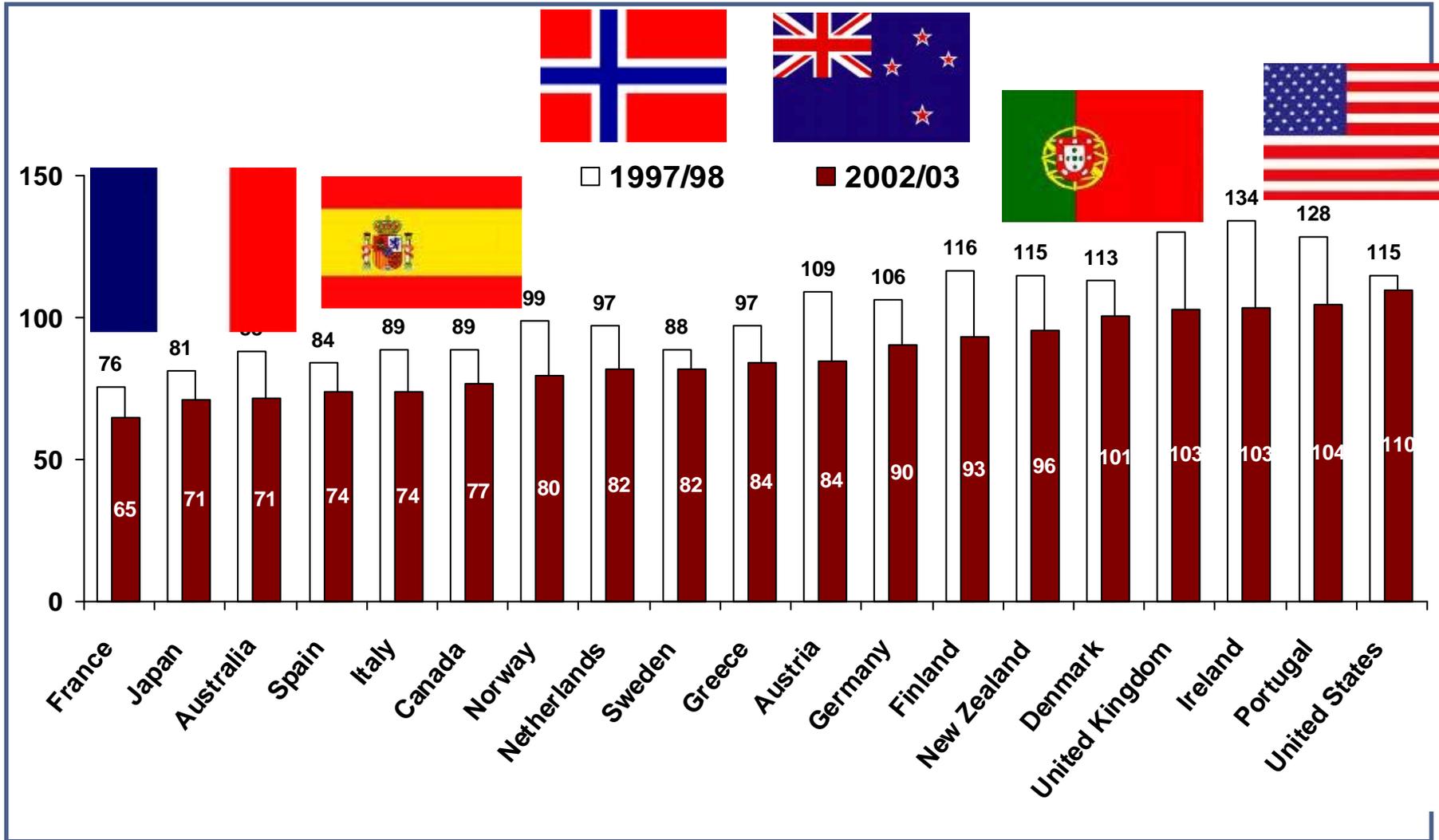
How do you fix the foundational issue: our healthcare system is so expensive and yet so ineffective??



Average health spend per capita (\$US PPP)



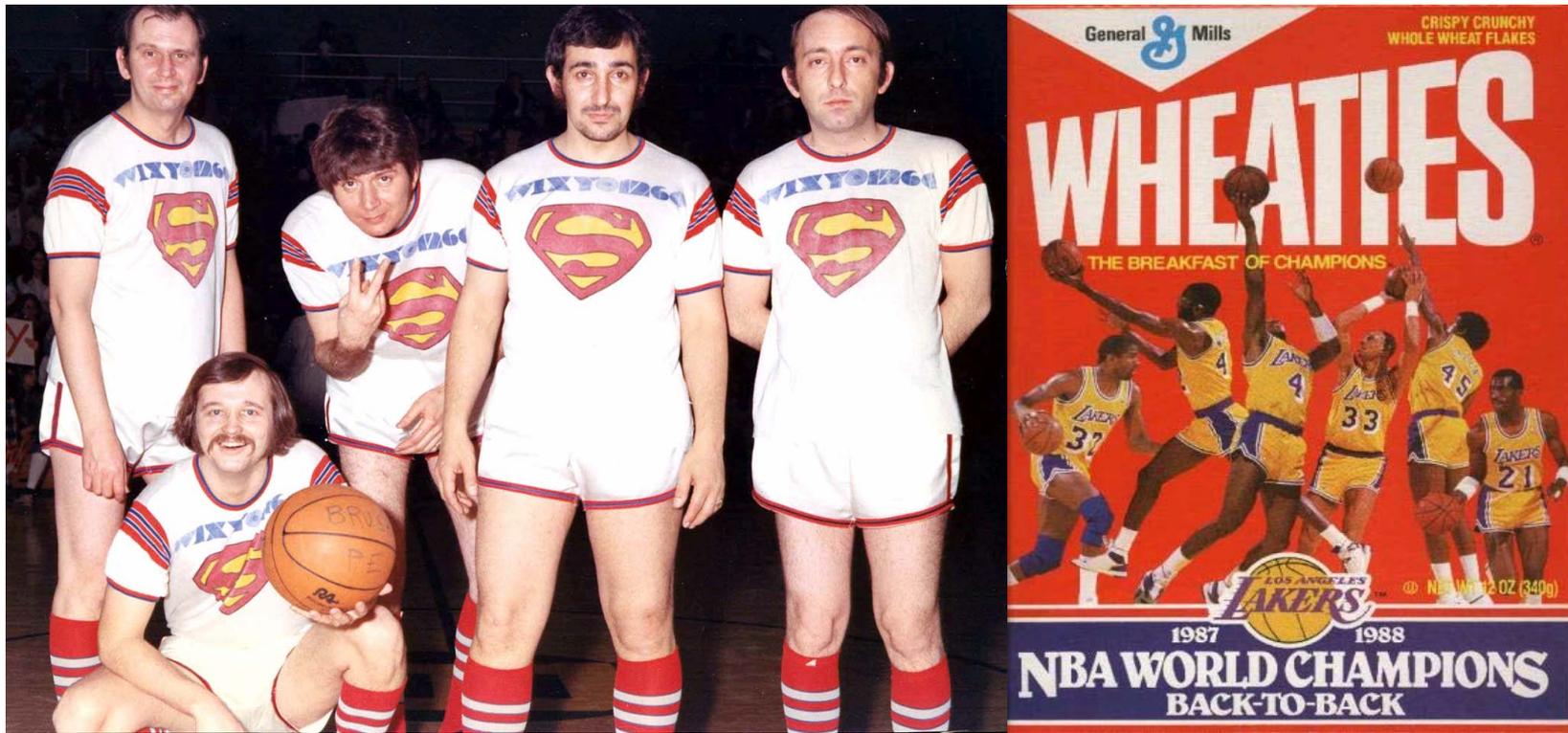
The World Health Organizations ranks the U.S. as the 37th best overall healthcare system in the world





“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

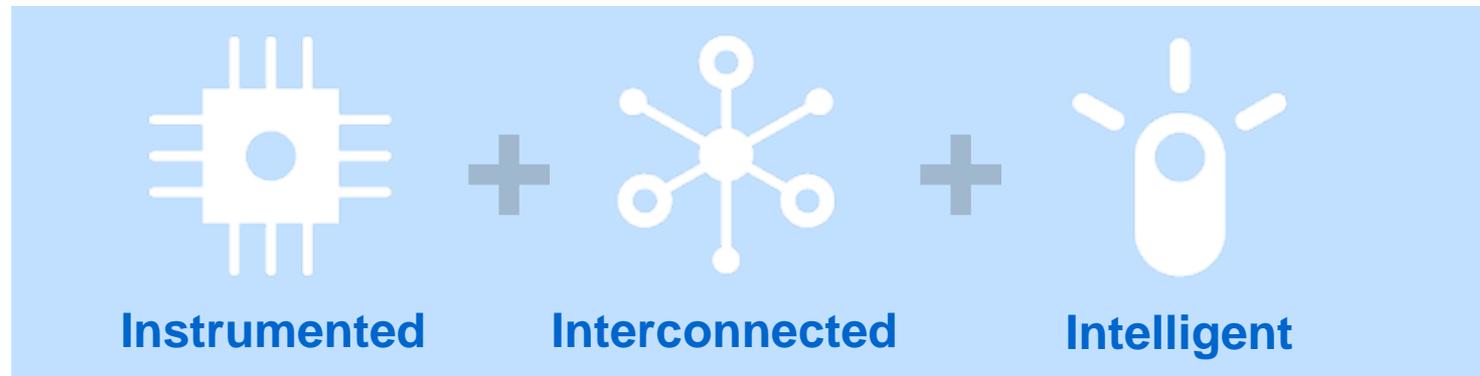
“ We don't have a healthcare delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure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

George Halverson, from “*Healthcare Reform Now*”

We need Smarter Healthcare



A smarter health system forges partnerships in order to deliver better care, predict and prevent disease and empower individuals to make smarter choices.



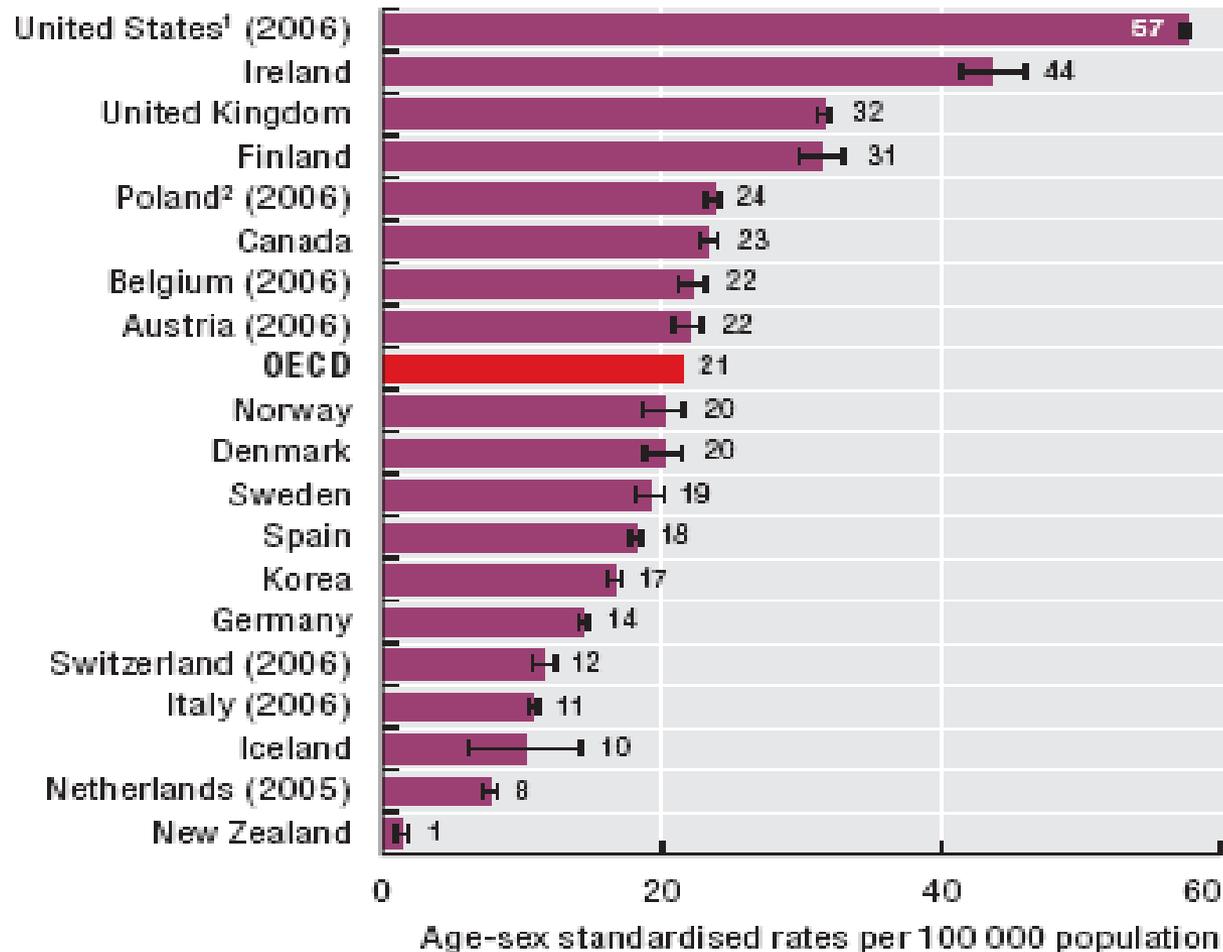
Improve operational effectiveness

Deliver collaborative care for prevention and wellness

Achieve better quality and outcomes

Chronic disease data from across developed countries highlights the need for improved primary care

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.

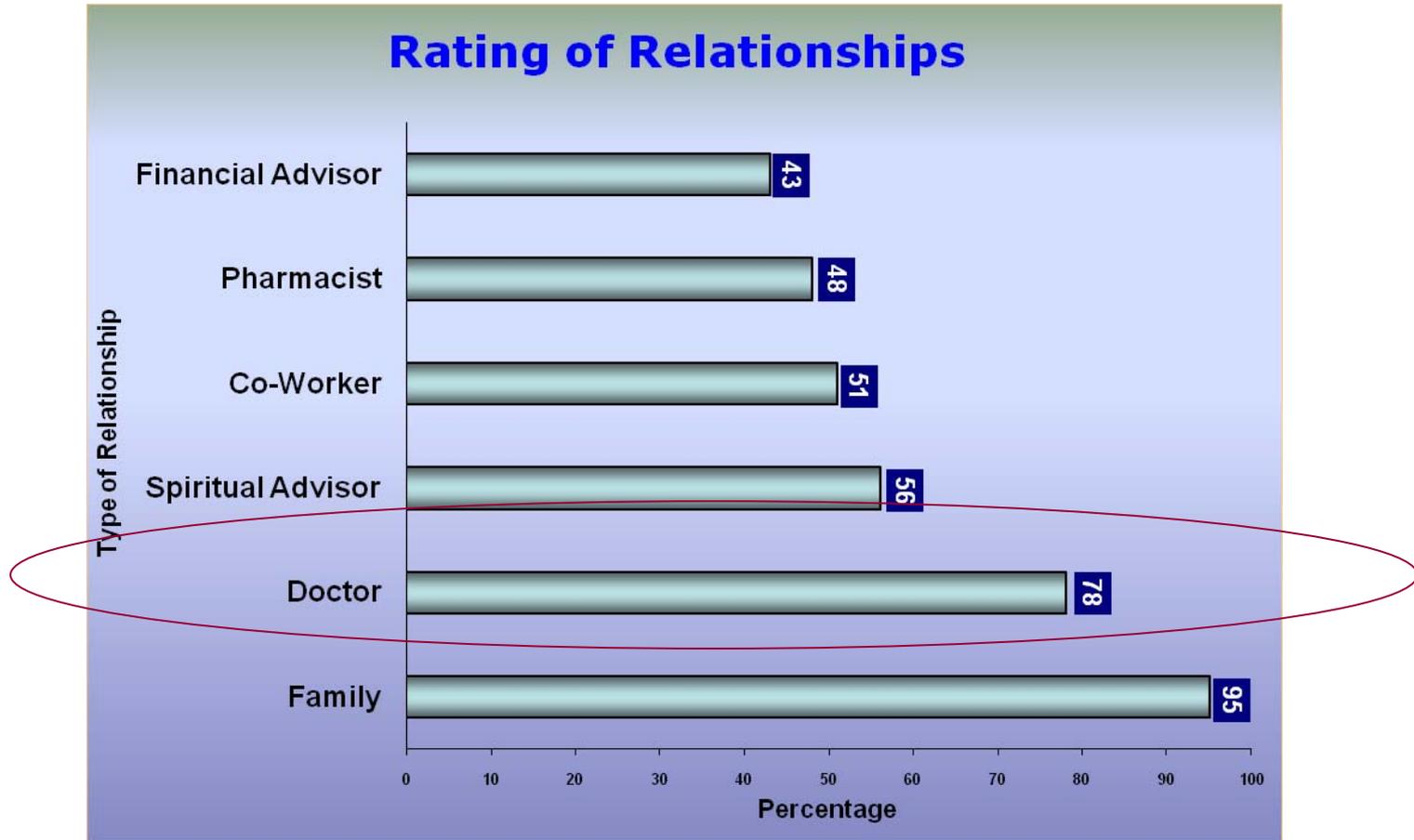
Source: OECD Health Care Quality Indicators Data 2009 (OECD).

Patient Centered Medical Home =
Advanced Primary Care



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



Source: Magee, J., *Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan*. 2003

How Connected Are You to Your Primary Care Physician?

“Not surprisingly, those patients with the strongest relationships to specific primary care physicians were more likely to receive recommended tests, medication adherence and preventive care. In fact, this sense of connection with a single doctor had a greater influence on the kind of preventive care received than the patient’s age, sex, race or ethnicity.”

Atlas, SJ Grant RW, et al. Ann Int Med 2009 :150 :325-335



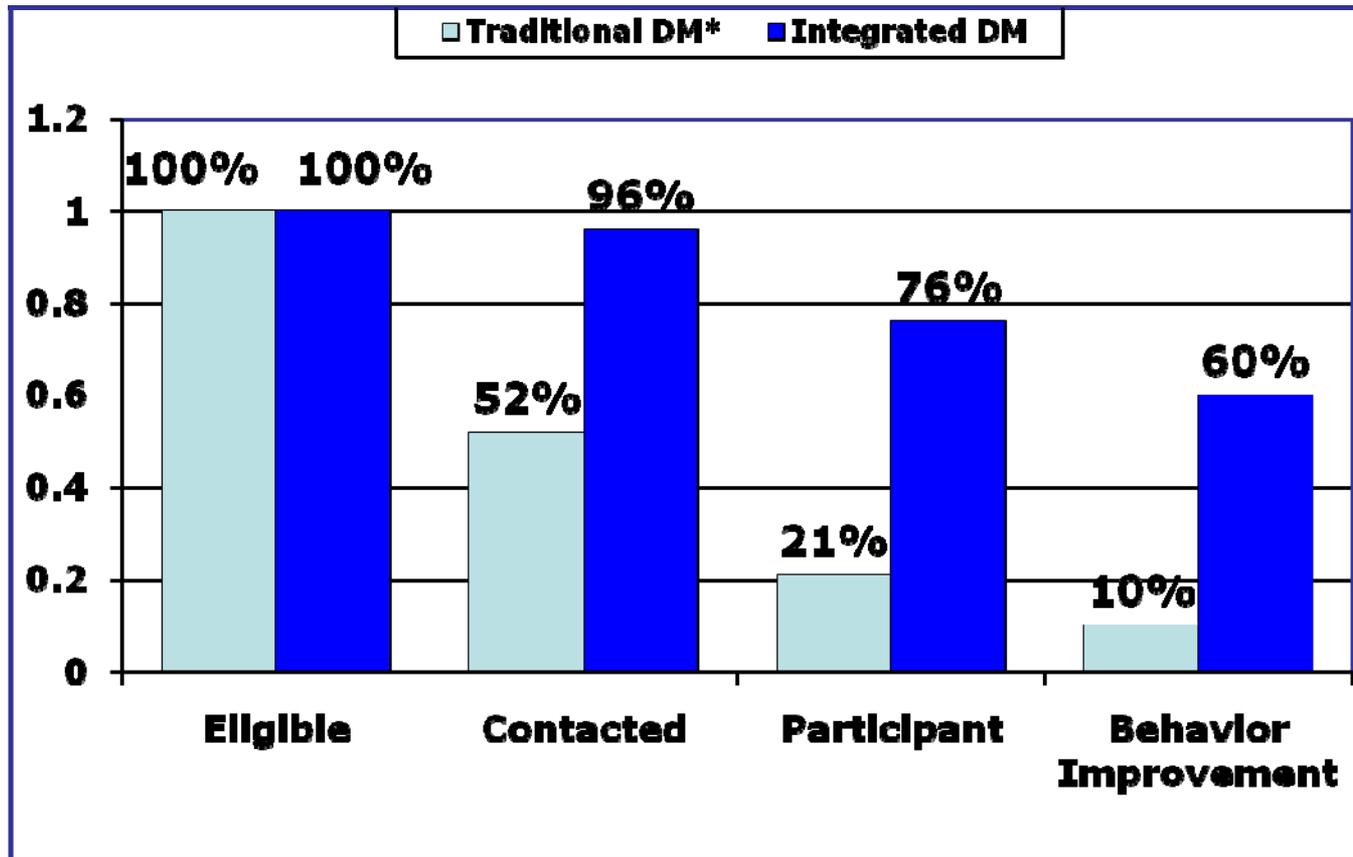
Physician-connected patients

Performance measure	Physician-connected patients (%)	Practice-connected patients (%)	p value
Mammography	78.1	65.9	<.001
Cervical cancer	86.4	80.2	<.001
Colorectal cancer	72.1	58.0	<.001
HbA1c in past year	90.3	74.9	<.001
HbA1c <8%	74.7	70.5	.004
LDL in past year	83.2	61.2	<.001
LDL<100mg/dl	77.0	67.2	.64

Study involved 155,590 patients seen in one of 13 primary care practice network sites

Patients attributed to physician, practice, or neither based on validated algorithm

Collaboration of Primary Care & Disease Management: PCMH Improves Disease Management Engagement Rates



N=320 patients enrolled in IDM at Gadsden (published in Journal of Disease Management 1 2007 & 2008)

* Lynch et al. Documenting Participation in a DM Program. JOEM 2006; 48(5)¹ Frazee et al. Leveraging the Trusted Clinician: Documenting Disease Management Program Enrollment. Disease Mgmt 2007; 10:16-29

Improved Care Experience

Pilots show a significant improvement in the patient and care giver experience*

- ❖ Patients report higher ratings on 6 out of 7 patient experience scales
- ❖ 10% of physician staff report burnout and high emotional exhaustion at 12 months in the medical home office, compared with 30% of the control staff, despite similar rates at baseline
- ❖ PCMH patients used more e-mail, phone, and specialist visits, but fewer emergency services
- ❖ At 12 months, there were no significant differences in overall costs

* "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation", Journal of Managed Care, Robert J. Reid, MD, PhD; Paul A. Fishman, PhD; Onchee Yu, MS; Tyler R. Ross, MA; James T. Tufano, MHA, PhD; Michael P. Soman, MD, MPH; and Eric B. Larson, MD, MPH; September 1, 2009 - 12:00:27 AM (CDT)

Primary Care Providers can serve a critical role in mental health delivery, from prevention through early detection, and effective ongoing care

During the past 20 years, the locus of mental health treatment in the United States has shifted from specialty mental health to primary care medical settings, and more than half of treatment for mental disorders now occurs in general medical settings *

* Druss BG, Mays RA Jr, Edwards VJ, Chapman DP. Primary Care, Public Health, and Mental Health. Prev Chronic Dis 2010;7(1). http://www.cdc.gov/pcd/issues/2010/jan/09_0131.htm.

The medical home model – core concepts

- ▶ **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 PCMH concept advocates enhanced access to comprehensive, coordinated, evidence-based, interdisciplinary care

Today's Care

My patients are those who make appointments to see me

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

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

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

Patients are responsible for coordinating their own care

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**

Care is determined by a **proactive plan to meet health needs, with or without visits**

Care is standardized according to **evidence-based guidelines**

We measure our quality and make rapid changes to improve it

A prepared team of professionals coordinates all patients' care

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

An **interdisciplinary team** works at the **top of our licenses** to serve patients

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 acute care issues

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

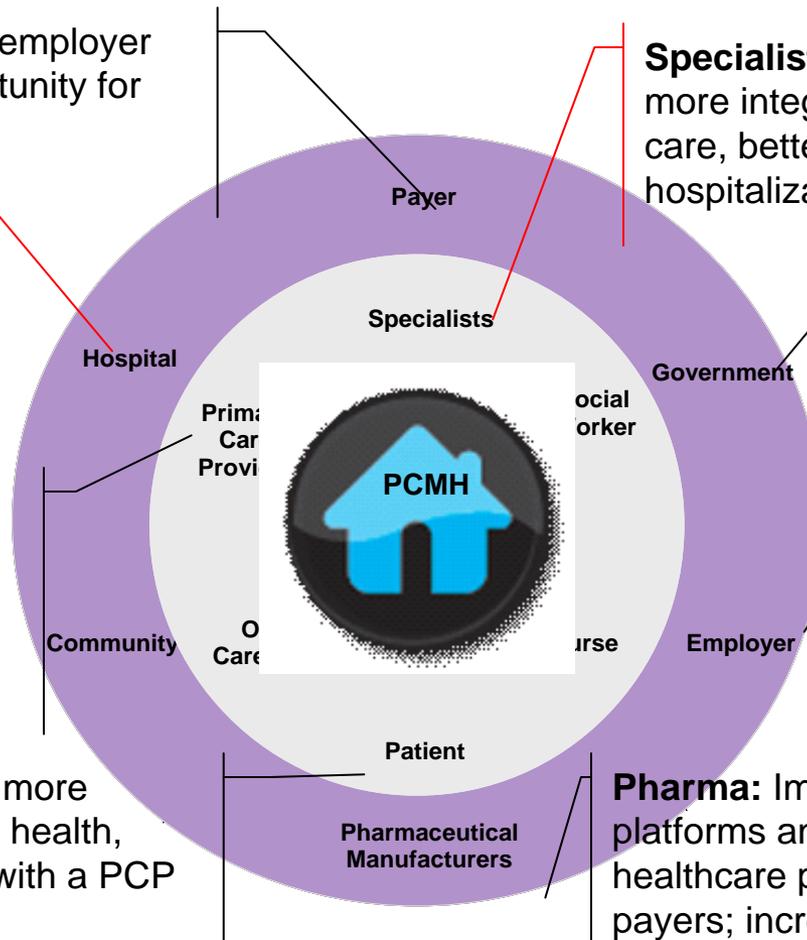
Patient: Better, safer, less costly, more convenient care and better overall health, productive long-term relationship with a PCP

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

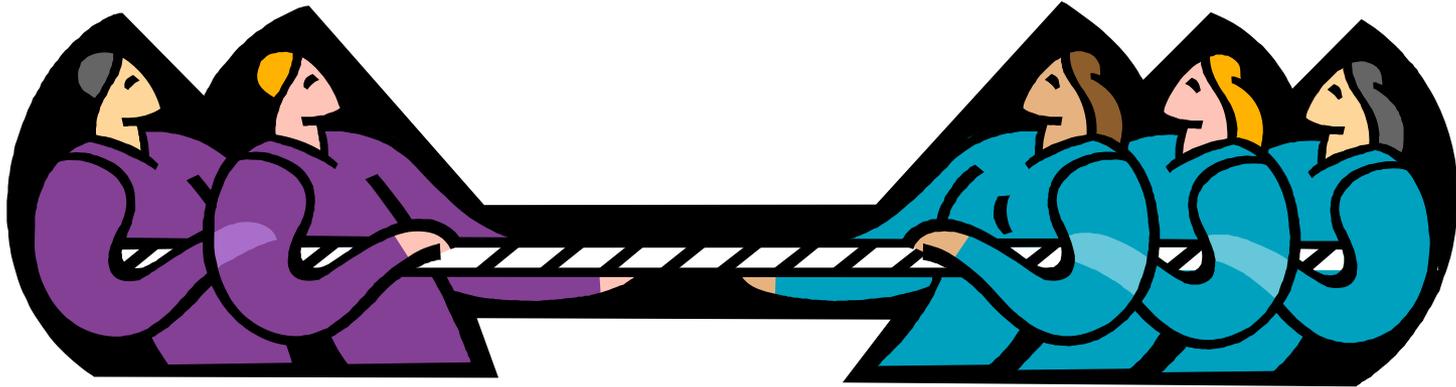
Government: Lower healthcare costs, healthier population

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



The Stalemate that blocks change



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

**B
U
T**

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

The Patient Centered Medical Home: A Model for Change!



Providers transform
practice, create value
with viable &
sustainable payment for
desired services

**A
N
D**

Employers & payers pay
for desired services
because primary care
demonstrates value AND
saves money

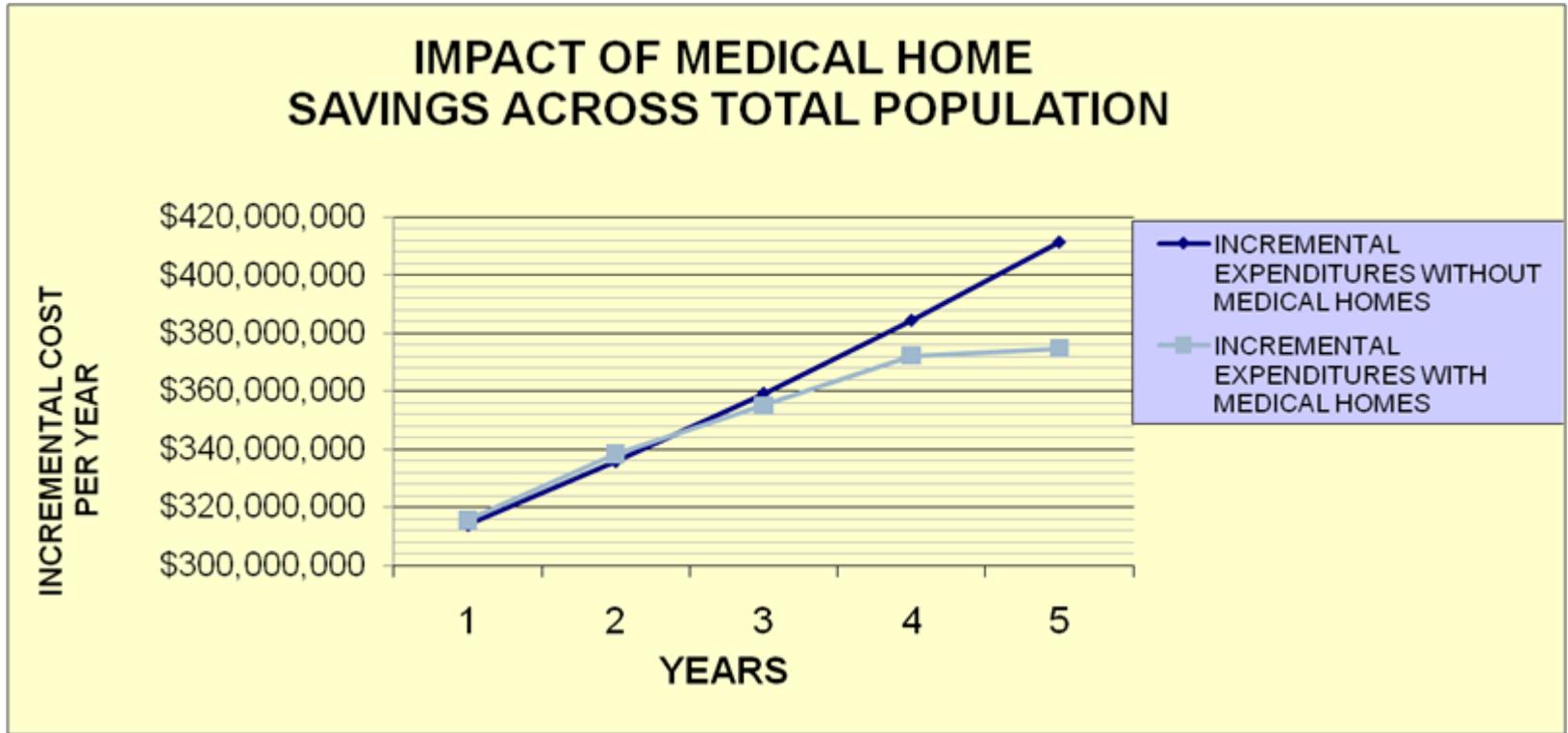
= **Practice
Transformation**

= **Payment Reform**

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

Vermont Financial Impact



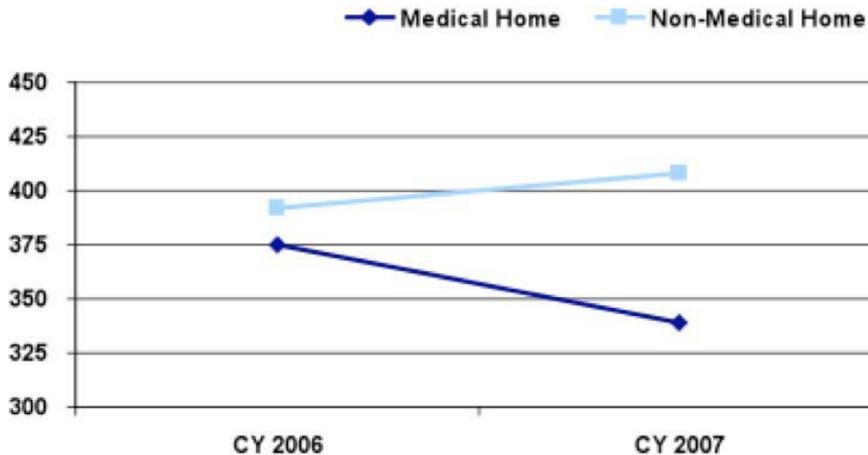
	2009	2010	2011	2012	2013
Percentage of Vermont population participating	6.7%	9.8%	13.0%	20.0%	40.0%
Participating population	42,179	61,880	82,332	127,045	254,852
# Community Care Teams	2	3	4	6	13

Geisinger Health System



Geisinger Medical Home Sites and Hospital Admissions

Hospital admissions per 1,000 Medicare patients



Source: Geisinger Health System, 2008.

Lewisburg Pennsylvania	Pre-Test period Jan - Oct 2006	First pilot year Jan - Oct 2007	Percent reduction
Hospital Admission	365/1000	291/1000	- 20%
Hospital re-admissions	15.2%	7.9%	- 48%
Cost			7% less

PCMH pilots: Compelling results

Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions

Group Health Cooperative of Puget Sound

- 29% Reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- Additional investment in primary care of \$16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients.

Community Care of North Carolina

- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.

Genesee Health Plan HealthWorks PCMH Model

- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

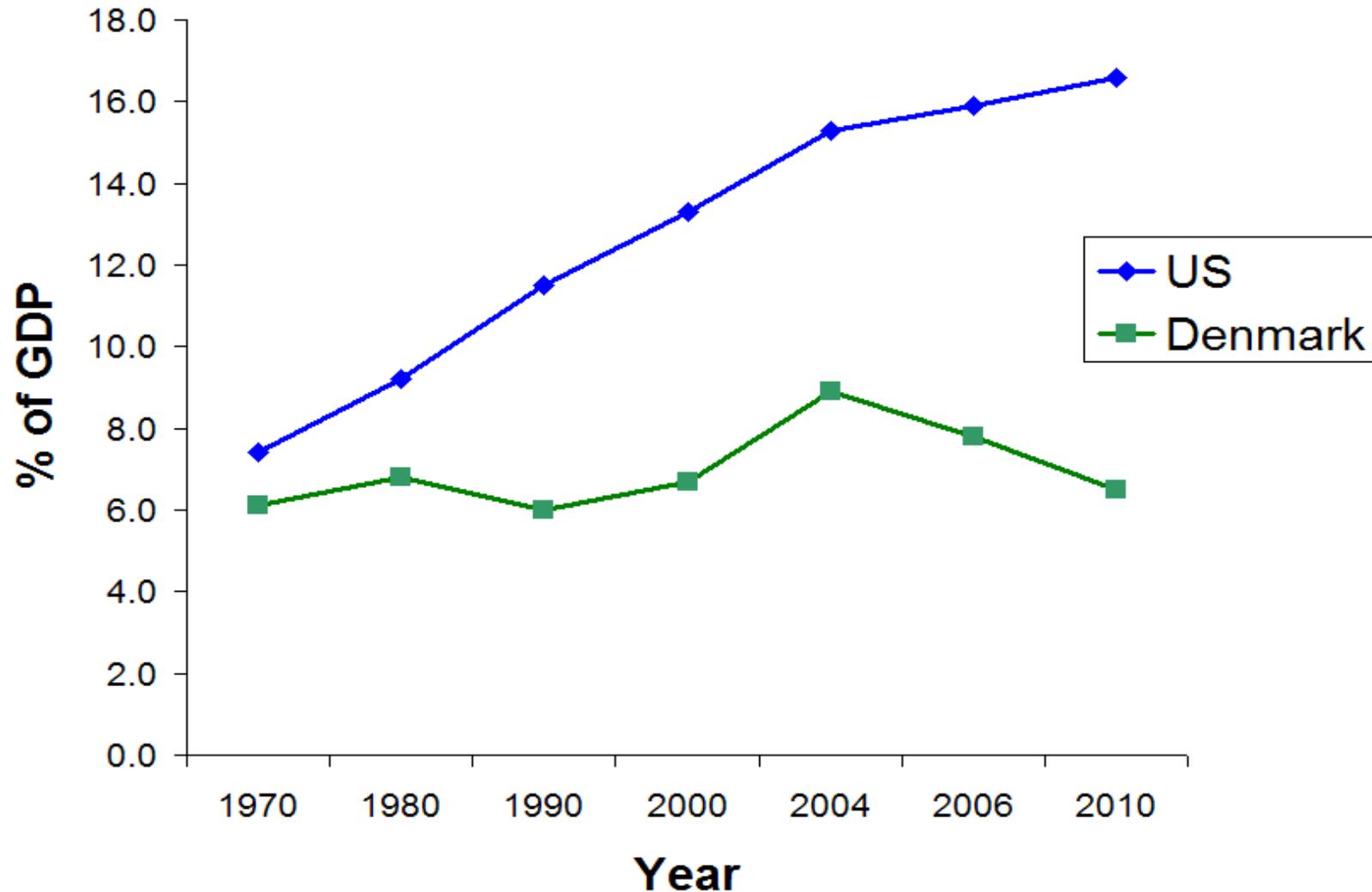
Colorado Medicaid and SCHIP

- Median annual costs \$785 for PCMH children compared with \$1,000 for controls, due to reductions in ER visits, and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).

Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days.
- Annual net Medicare savings of \$1364 per patient and \$75,000 per Guided Care nurse deployed in a practice.

In Denmark, PCMH adoption is a decade ahead and Healthcare costs are dramatically lower*



Source: OECD Health Data 2006: Statistics and Indicators for 30 Countries

* Healthcare costs as % of GDP



Creating Value Through Patient Centered Medical Homes

Bob Kocher, MD
National Economic Council
Special Assistant to the
President

October 22, 2009

Moving towards a more coordinated system

Cooperating in new efforts to better coordinate care

- Accountable Care Organizations (ACO's)
- Community health teams
- HIT

Patient Centered Medical Homes

Working with innovative reimbursement structures

- Bundled payments
- Expanded pay-for-Quality
- Readmission incentives
- Outlier reductions

Improving health outcomes

- Prevention (primary and secondary)
- Chronic disease management
- Patient engagement and education
- Data transparency



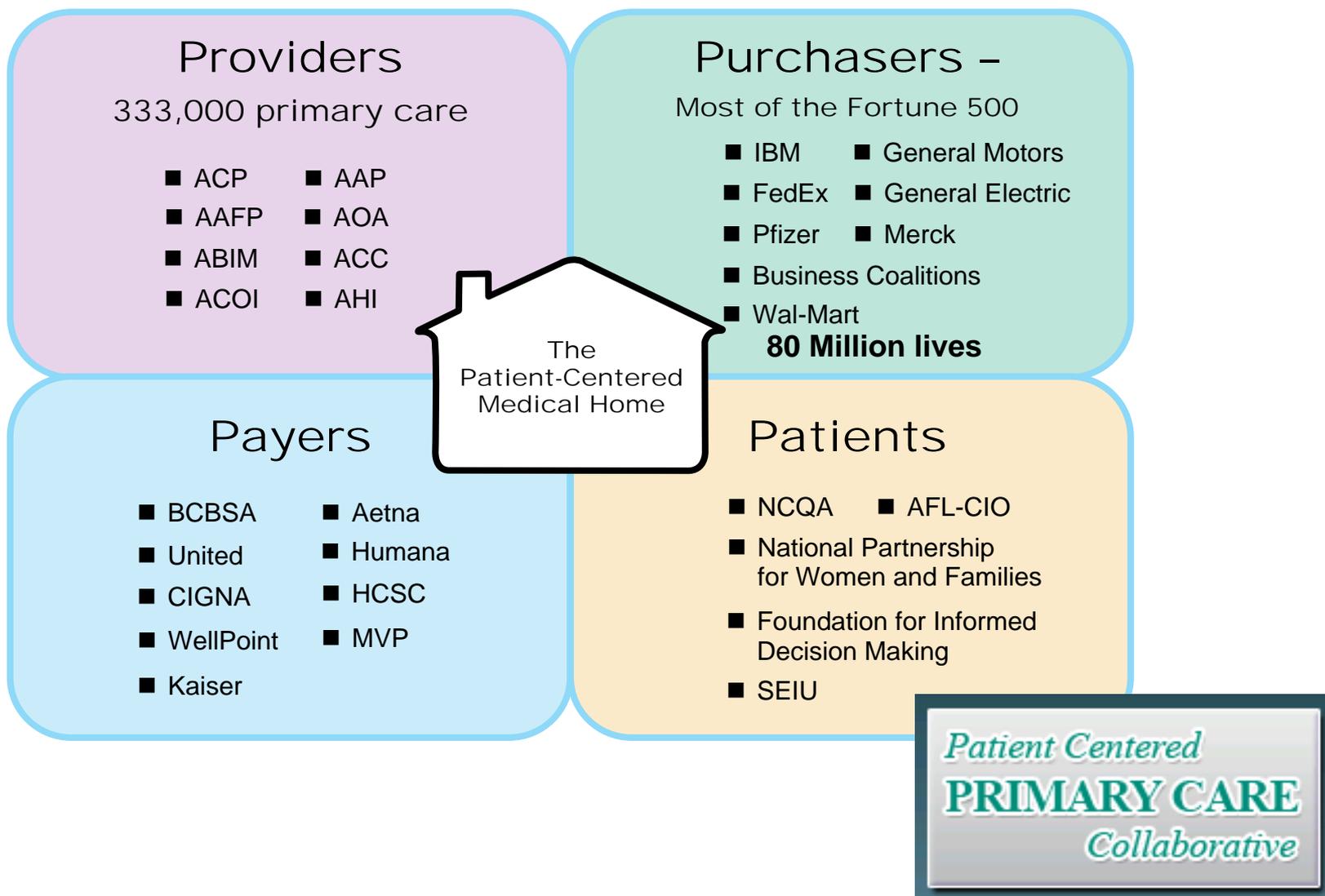
Primary Care Providers need a technology “on ramp” for PCMH implementation

- **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**

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

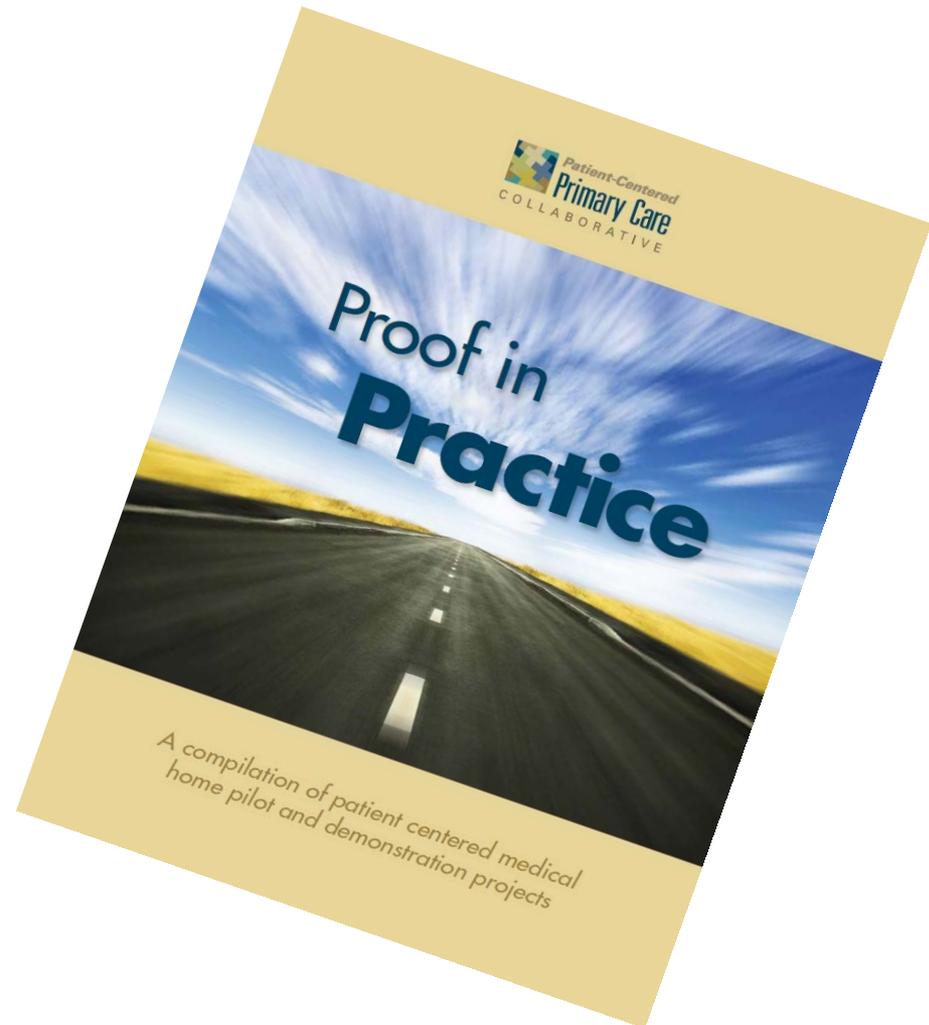
The Patient Centered Primary Care Collaborative: Examples of broad stakeholder support and participation



Patient Centered Primary Care Collaborative

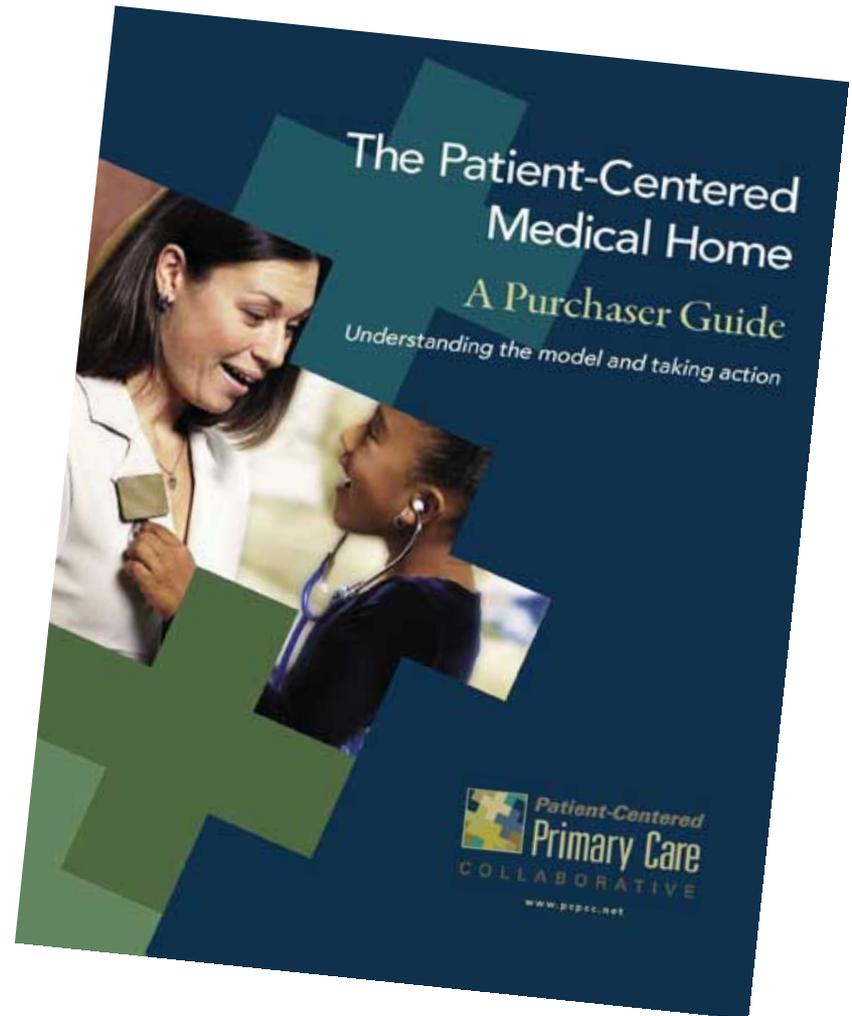
“Proof in Practice– A Compilation of Patient Centered Medical Home Pilot and Demonstration Projects” Released October 2009

- ▶ 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.



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 medical home: What, why and how? IBM IBV whitepaper: <http://www-935.ibm.com/services/us/gbs/bus/html/gbs-medical-home.html>
- ▶ Patient-Centered Primary Care Collaborative: <http://pcpcc.net/content/patient-centered-medical-home>
- ▶ PRISM: <http://www.prism1.org>
- ▶ American Academy of Family Physicians: www.aafp.org/online/en/home/membership/initiatives/pcmh.html
- ▶ American College of Physicians: www.acponline.org/advocacy/where_we_stand/medical_home
- ▶ American Academy of Pediatrics: www.medicalhomeinfo.org/
- ▶ TransformMED: <http://www.transformed.com/transformed.cfm>
- ▶ NCQA Recognition: www.ncqa.org/tabid/631/Default.aspx
- ▶ MedHomeInfo: www.medhomeinfo.org

Questions?

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