Patient Centered Medical Home And Oral Health

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IBM's Director Healthcare Transformation
President Patient Centered Primary Care Collaborative
Paul Grundy MD MPH Bio

- “Godfather” of the Patient Centered Medical Home
- IBM Global Director Healthcare Transformation
- President of PCPCC
- Member Institute of Medicine
- Member Board ACGME
- Professor Univ. of Utah Department Family Medicine
- Winner NCQA national Quality Award
- A Leader of MOH level taskforce primary care transformation 8 nations: USA, Canada, New Zealand, Australia, Holland, Denmark, UK, Belgium,
- Univ. of California MD, John Hopkins Trained
Course Objectives:

Participants will be able to:

- Define the current landscape of Health Care Reform transformative efforts as it relates to ambulatory care;
- Identify the basic tenets of:
  - Population Management,
  - Patient Centered Medical Home,
  - Accountable Care Organizations,
  - Value Based Purchasing;
- Define care coordination opportunities between primary and specialty care services;
- Verbalize the role of Health Information Technology in the advancement of ambulatory care and improved patient outcomes.

Disclosure:

I am a full time Employee of IBM I WILL NOT discuss any pharmaceuticals, medical procedures, or devices
Co-location of Medical and Dental Services

- Oral health care can no longer be separated from the rest of the body. Having good oral health is key to optimal general health. Oral Health is part of a PCMH and it works both ways is integrated. We Do have necks!!
Dental Health a cornerstone of PCMH

• Good oral health means a higher quality of life and fewer related medical problems.
• Good oral health is integrated into comprehensive care
• Good dental health and a good oral health team WILL help prevent or reduce the consequences of other diseases and conditions.
• Good oral health is a sentinel in so many ways to coordinated total care
Away from Episode of Care to Management of 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

System Integrator
- Population Health
- Per Capita Cost
- Patient Experience
- Public Health

Hospital

Community Health

Per Capita Cost

Public Health

Patient Experience

Population Health
Rural New York

- Commercial/ASO insurance cost decreased from $380 per-patient-per-month in 2009 to $316 in 2012

- Costs for Medicaid patients dropped from $334 to $266, according to a recent “risk adjusted” analysis.

**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

**PCMH CARE**

- Our patients are the population community
- Care is determined by a proactive plan to meet patient 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 & consultations, and follow-up after ED & hospital
- A multidisciplinary team works at the top of our licenses to serve patients

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
36.3% Drop in hospital days
32.2% Drop in ER use
12.8% Increase Chronic Medication use
-15.6% Total cost
10.5% Drop Inpatient specialty care costs
18.9% Ancillary costs down
15.0% Outpatient specialty down

PCMH Lower Costs
Aug 5th 2013 Pennsylvania

• 44% reduction in hospital costs

• 21% reduction in overall medical costs.

• 160 PCMH practices Pennsylvania from 2008 to 12

• Number of patients with poorly controlled diabetes declined by 45%.

Jeffrey Bendix modernmedicine.com/
• 19.1% lower rate of adult hospitalization.
• 8.8% lower rate of adult ER visits.
• 17.7% lower rate ER visits (children under age 17)
• 7.3% lower rate of adult high-tech radiology usage

VS other non-PCMH designated primary care physicians.

3,017 Physicians

Medical home physicians help patients avoid ERs and admissions by evening hour appointments, weekend and same-day appointments.

WellPoint PCMH Preliminary Year 2 Highlights  In Sept Issue Health affairs 2012

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
• 1/3 less cardiac intervention needed
• 60% less complication Diabetes
Build your own corporate PCMH

Per Employee Per Month Health Costs
Post Implementation

Actual client data: Midwest Hospital with 12,135 employees 1 year self-funded for group health
**Trajectory to Value Based Purchasing:**
Achieving Real Care Coordination and Outcome Measurement

- **Primary Care Capacity:** Patient Centered Medical Home
- **HIT Infrastructure:** EHRs and Connectivity
- **Operational Care Coordination:** Embedded RN Coordinator and Health Plan Care Coordination $
- **Value/Outcome Measurement:** Reporting of Quality, Utilization and Patient Satisfaction Measures
- **Value-Based Purchasing:** Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)
- **Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement**

Source: Hudson Valley Initiative
Defining the Care Centered on 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
“We do the best heart surgeries.”
Patient Centered Medical Homes (PCMH) within the Federal Employees Health Benefits (FEHB) Program

- A growing body of evidence supports **investment in PCMH** – SO we are!!
- There must be a plan for all FEHB lives enrolled in the practice to be included in a reasonable timeframe.

- ACA 2334
MobileFirst Patient Consumer
Mobile Sensing emotion for mental health status -- analyzes 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 -- benefit design feedback
Practice transformation away from episode of care

Master Builder

Preventive Medicine → Case Manager → Behavioral Health
Chronic Disease Monitoring
Medication Refills → Medical Assistants
Acute Care → Nursing
Test Results

Source: Southcentral Foundation, Anchorage AK
PCMH Parallel Team Flow Design
The glue is real data not a doctors Brain

Chronic Disease Monitoring
- Medication Refills

Acute Care
- Test Results
- Preventive Medicine

Point of Care Testing
- Acute Mental Health Complaint

Chronic Disease Compliance Barriers

Healthcare Support Team
- Case Manager
- Clinician
- Medical Assistants
- Behavioral Health

Source: Southcentral Foundation, Anchorage AK
Healthcare will Transform

- Data Driven
- Every patient has a plan
- Team based
- Managing a Population Down to the Person
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”
New $ Dials

• Complex Chronic Care Management payment codes. authorize payments to physicians for the work that goes into managing complex patients outside of their actual office visits.

• House Energy and Commerce Committee Bill repeals SGR moving Medicare payments away from FFS toward new, innovative models.

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

Those who are well or think they are well

Those with severe, acute illness or injuries

Those with chronic illness

Those who are well or think they are well
Benefit Redesign

- Cost 2013 $16,351 emp on ave paying $4,565
- Federal government Final Rules wellness incentives.
- Smoker --employer may increase your insurance premiums by up to 50 percent.
- Overweight, you may look at a 30 percent surcharge.
- And employers may also reduce premiums by up to 30 percent for normal weight.
benefit design reference pricing

• California Public Employees' Retirement System (CalPERS), from 2008 to 2012.
• Insurer sets limits on the amount to be paid for a procedure, with employees paying any remaining difference.
• Shift by Patients from high to low cost 55.7%.
• Hospitals reduced their prices by an average of 20%.
• Accounted for $2.8 million in savings in 2011.

http://content.healthaffairs.org/content/32/8/1392.abstract
Health Aff August 2013 vol. 32no. 8 1392-1397
PCMH 2.0 in Action

Community Care Team
- Nurse Coordinator
- Social Workers
- Dieticians
- Community Health Workers
- Care Coordinators

Public Health Prevention
- HEALTH WELLNESS

A Coordinated Health System
- Health IT Framework
- Global Information Framework
- Evaluation Framework
- Operations
http://www.amazon.com/Familiar-Physician-Saving-Doctor-ObamaCare/dp/1614487375/ref=sr_1_1?ie=UTF8&qid=1375885302&sr=1-1&keywords=The+Familiar+Physician
Blue Plan Care Delivery Innovations
PCMH Level Care in market or in development in 49 states, District of Columbia and Puerto Rico

United HC, Humana, Aetna, CIGNA, Kaiser Martins Point, CDPHP, Priority,

PCPCC
Note: Information as of October 18, 2012. Program accessibility to National Account members varies by market.
Geisinger’s Proven Health Navigator Model serving Medicare Patients in rural Pennsylvania reported 7.1% savings over expected costs from 2006-2010 with an ROI of 1.7

• **Genesee Health Plan** in Flint, Michigan, reported PCMH services helped reduce ER visits by 51% between 2004 and 2007 and reduced hospital admissions by 15% between 2006 and 2007
• **WellPoint’s** PCMH model in New York yielded risk-adjusted total PMPM costs that were 14.5% lower for adults and 8.6% lower for children enrolled in the medical home
• **CareFirst Blue Cross Blue Shield** of Maryland yielded an estimated 15% pmpm savings in the first year and $98 million in savings over two years
• **Group Health of Washington** reported overall cost savings of $17 PMPM including 29% fewer ER visits and 11% reduction in hospitalizations for ambulatory sensitive conditions
• **Oklahoma Medicaid** reported $29 PMPM savings
• **HealthPartners** in Minnesota reported 39% reduction in ER visits, 24% fewer hospitalizations, 40% reduction in readmission rates and 20% reduction in inpatient costs
# Why the Medical Home Works: A Framework

Visit www.pcpcc.net for more information.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Definition</th>
<th>Sample Strategies</th>
<th>Potential Impacts</th>
</tr>
</thead>
</table>
| 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 | 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 |
| 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 | Providers are less likely to order duplicate tests, labs, or procedures  
Better management of chronic diseases and other illness improves health outcomes |
| 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 | Focus on wellness and prevention reduces incidence / severity of chronic disease and illness |
| 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. | Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions. |
| 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 | |
PCMH Growth
A journey to higher quality lower cost quality as well as efficiency
Australia recognizes evidence in support of Patient-Centered Medical Homes is in, and it’s compelling.

- Improved access to care;
- Improved clinical outcomes;
- Better management of chronic and complex disease;
- Decreased use of inappropriate medications;
- Decreased hospital admissions and readmissions; and
- Improved palliative care services.

Therefore the Australian government will adopt Patient-Centered Medical Home as standard of care.
Survey Of 5 European Countries Suggests Patient-Centered Medical Homes Would Improve Family Medicine Primary Care

2013/03/19

http://content.healthaffairs.org/content/early/2013/03/19/hlthaff.2012.0184.full.html
Patients not shortchanged
PCMH as the Foundation

The right care foundation
The right time
The right price
THANK YOU
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## Thirteen Year Cumulative Percent Change in Cost

<table>
<thead>
<tr>
<th>Year</th>
<th>VHA Cost Per Patient</th>
<th>Average Medicare Payment/Enrollee</th>
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