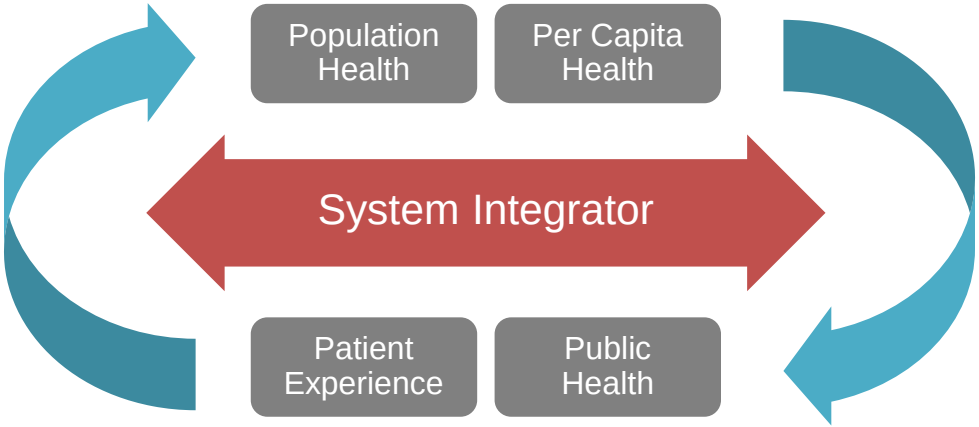
Paul Grundy MD, MPH
IBM Chief Medical Officer Director, Healthcare Transformation Healthcare Industry

GPSC
General Practice Services Committee

Patient/Primary Medical Home Foundation for Transformation

@Paul_PCMH

Away from Episode of Care to Management of Population with Data



Community Health

The System Integrator

- Creates a partnership across the medical neighborhood
- Drives PCMH primary care redesign
- Offers a utility for population health and financial management

No matter what it's called...

...we're working together to create an integrated system of care.

GPSC

General Practice Services Committee

Key principles

- **Personal healer** – each patient has an ongoing personal relationship with a physician for continuous, comprehensive care
- **Whole person orientation** – physician is responsible for providing 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
- **Quality and safety are hallmarks of the medical home** – Evidence-based medicine and clinical decision-support tools guide decision-making
- **Enhanced access to care is available** – systems such as open scheduling, expanded hours, and new communication paths between patients, their physician and practice staff
- **Payment is appropriate** – added value provided to patients who have a patient-centered medical home

Person & Family Centered. Primary care is focused on the whole person their physical, emotional psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.

Continuous. Dynamic. Trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care.

Comprehensive and Equitable. Primary care addresses the whole-person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health

Team-Based and Collaborative. Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.

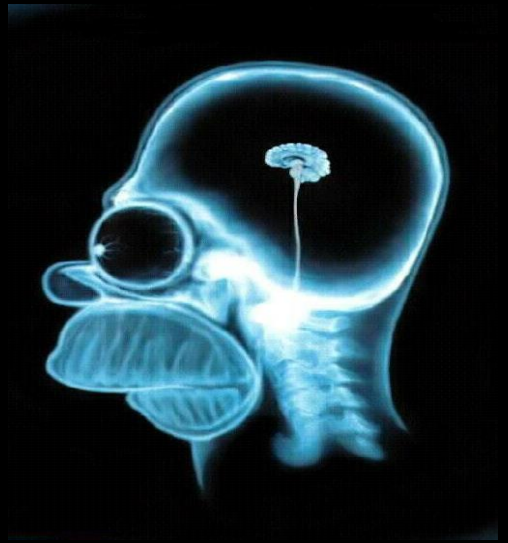
Coordinated and Integrated. Primary care integrates the activities of those involved in an individual's care, across settings and services.

Accessible. with easy, and with routine access to their health information.

High-Value. Primary care achieves excellent, equitable outcomes for individuals and families, including using health care resources wisely and considering costs to patients, payers and the system.

Smarter Healthcare -- a no Brainer

36.3%	Drop in hospital days
32.2%	Drop in ER use
12.8%	Increase in chronic medication
-15.6%	Total cost
10.5%	Drop in inpatient specialty care costs
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

24 APRIL 2015, MICHIGAN PATIENT-CENTERED MEDICAL HOME PROGRAM SHOWS STATEWIDE TRANSFORMATION OF CARE YEAR 6

9.9%	Decrease in adult ER visits
27.5%	Decrease in adult ambulatory care sensitive inpatient stays
11.8%	Decrease in adult primary care sensitive ER visits
8.7%	Decrease in adult high-tech radiology usage
14.9%	Decrease in pediatric ER visits
21.3%	Decrease in pediatric primary-care sensitive ER visits

4,022 primary care doctors at **1,422 practices** around the state in its sixth year of operation.
These practices care for more than **1.2 million** BCBSM members.

Sept 2016, Michigan patient-centered medical home program shows statewide transformation of care YEAR 7

15%	Decrease in adult ER visits
21.4%	Decrease in adult ambulatory care sensitive inpatient stays
18.1%	Decrease in adult primary care sensitive ER visits
12.7%	Decrease in adult high-tech radiology usage
17.2%	Decrease in pediatric ER visits
22.7%	Decrease in pediatric primary-care sensitive ER visits

4,534 primary care doctors at **1,638 practices** around the state in its seventh year of operation. These practices care for more than **1.4 million** BCBSM members.

http://www.bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/partners-report.pdf

LESSON #1

Gather together (get everyone around the table)

BCBSM's facilitation of quarterly meetings with all PO leaders (approximately 350) has led to cross-collaboration and synergistic partnerships among providers across the state, as well as the formation of a Primary Care Leadership Committee that provides review and guidance on PGIP policies and programs.

LESSON #5

Nurture effective and stable leadership

The Physician Group Incentive Program (PGIP) has catalyzed the formation of over 40 Physician Organizations (POs) that have led and supported practices in revolutionizing the delivery of health care in Michigan.

LESSON #4

Offer meaningful financial support

The PGIP program has used a combination of incentive reward payments to POs and value-based reimbursement for individual physicians to ensure providers have the financial support needed to succeed.

LESSON #2

Demand federal commitment, action and coordination

PGIP medical leaders have testified before Congress regarding the value-based reimbursement model and the importance of the federal government supporting and recognizing regional practice transformation efforts.

LESSON #7

Spark physician enthusiasm

"Relentless incrementalism" is a PGIP motto, and PGIP initiatives are designed to support and reward step-by-step progress through the celebration of provider and program best practices at quarterly meetings.

LESSON #6

Offer technical assistance and collaborative learning

PGIP provides practices with technical assistance and opportunities for collaborative learning by hosting learning collaboratives, providing education and guidance and funding a Care Management Resource Center.

LESSON #8

Encourage multi-payer participation

The PGIP program provided the foundation for the five year Michigan Multi-Payer Advanced Primary Care Practice Demonstration program.

LESSON #10

Embrace team-based approaches that extend beyond the practice

POs and practices deliver multi-disciplinary team-based care through access to a Provider-Delivered Care Management (PDCM) program, behavioral health providers and embedded pharmacist care managers.

LESSON #3

Obtain timely, accessible and useful data

The PGIP PCMH/PCMH-N program provides financial support to POs and practices to build the capacity for population management through use of integrated patient registries and performance reporting.

LESSON #9

Establish realistic time tables for evaluation

Underlying the PGIP philosophy of relentless incrementalism is the understanding that practice transformation is a long-term process, and programs must be allowed to stabilize and mature before results are evaluated.

Association between elements of the PCMH model and clinical quality in the Veterans Health Admin

JAMA -May 1, 2017

http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2623525


I
HERDING
CATS


I WANT TO THANK
PURINA
Friskies
Feed The Senses
NO ONE.
Facebook/Friskies

Payment reform requires more than one dial

Fee for...

health value outcome process belonging service satisfaction

MAYBE WHO PAYS IS THE WRONG QUESTION

Rather

Who do we pay?
How do we pay them?
For what, exactly, are we paying?

Because the way we are paying now ineluctably drives us toward paying too much, for not enough of the right kind of care, and for things we don’t even need.

Advanced Primary Care Alternative Payment Model (APC-APM)

Primary Care Global Payment

- Per patient per month
- Covers a defined set of face-to-face evaluation and management services
- Prospective, risk adjusted payment

Performance-Based Incentive Payment

- Paid prospectively quarterly; reconciled annually
- Based on performance measures, including quality and cost

Population-Based Payment

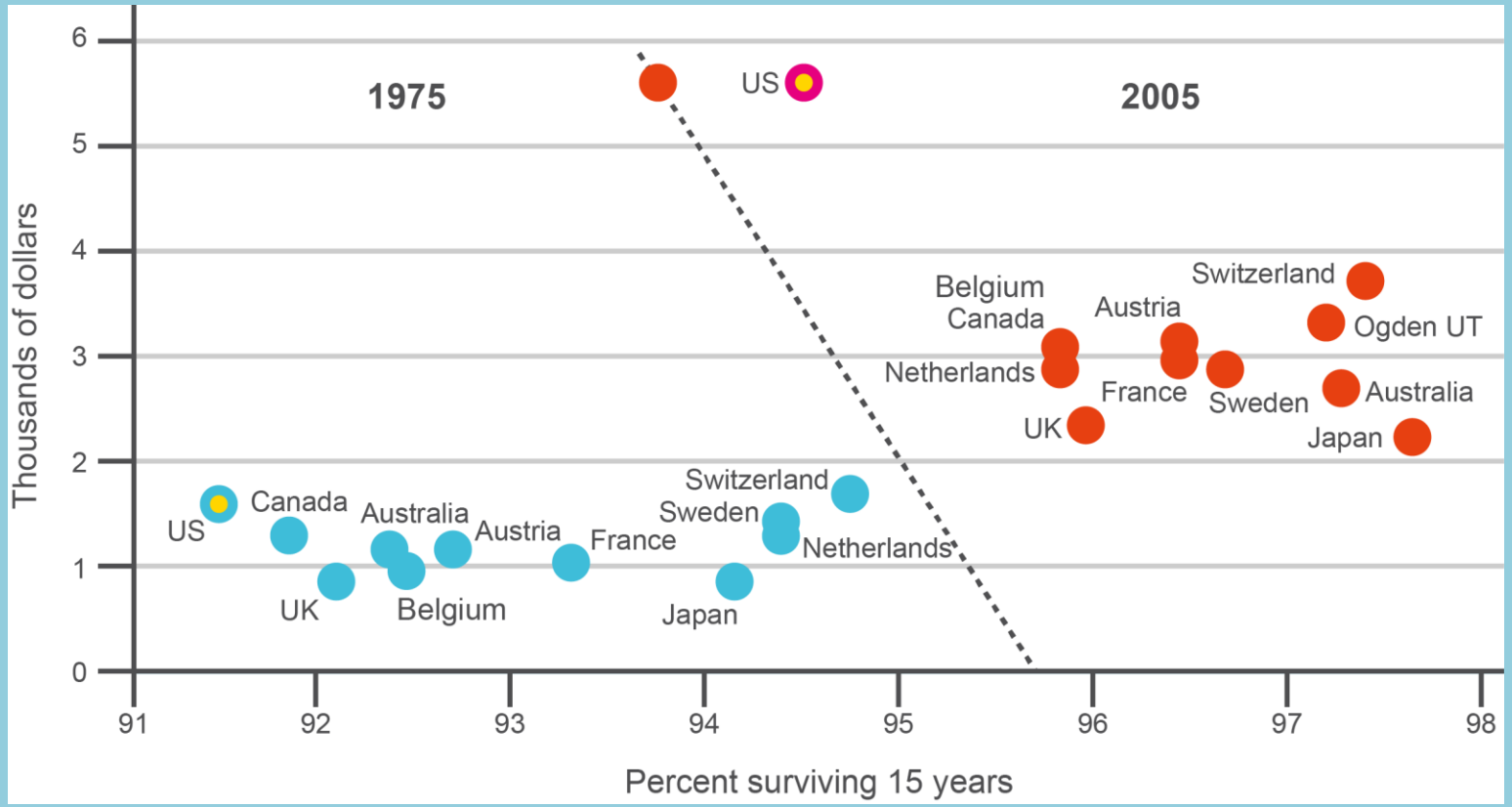
- Per patient per month
- Covers non-face-to-face patient services
- Prospective, risk adjusted payment

Fee-For-Service Payment

- As medically/clinically needed
- Based on relative value units

Driving factor 1: **Unsustainable Cost**

(USA 2012)



Driving factor 2:
Data

"The idea of cognitive healthcare – systems that learn – is real, and it's already mainstream," said IBM CEO Ginni Rometty in her opening keynote address to a packed auditorium at the 2017 HIMSS Convention and Exhibition. “ IT can change almost everything about healthcare."

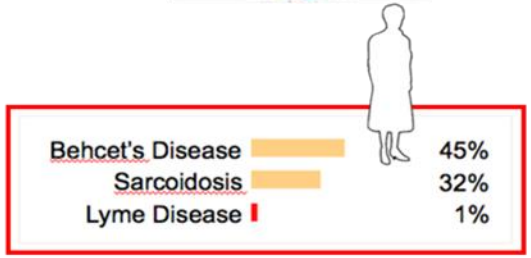
Leveraging Watson for Knowledge- and Data-Driven Insights:

*Support **business continuity** and **growth***

- Medical literature
- Clinical guidelines
- Key textbooks
- Social determinants

Published Knowledge

WATSON



*Closing the **translational knowledge** gap*

- Claims data
- Health risks & behaviors
- Community-based data
- HR workforce data

Observational Data

Patient Care & Insights

*Enabling new **personalized and population health** insights*

***Knowledge/Data-driven Insights** for **Better Health Decisions** and **Prevention of the Next 20%** Who Could Cost 80%.*

VALUE BASED CARE COMPONENTS

Risk Analytics

- Actuarial Cost Analytics
- Contract Management
- Quality and cost reporting

Practice Analytics

- Physician Efficiency profiles
- Episode Efficiency profiles
- Drug profiles
- Cost of care analysis
- Imaging
- Leakage

ANALYTICS

Case Management

Manage high-cost patients (top 5%)

- Predictive modeling
- Patient risk stratification
- Readmissions
- ER usage
- Medication management
- Referral management

Population Management

Manage entire population

- Patient Stratification
- Preventive/Chronic gaps
- Visit compliance
- Rx / Lab compliance
- Self management
- ER, Hospital, Readmissions

CARE DELIVERY

DATA FOUNDATION

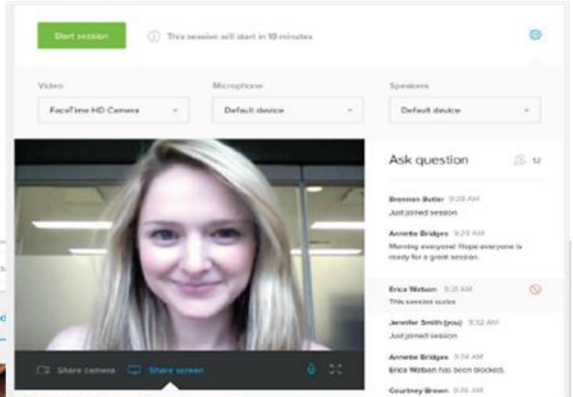
Driving factor 3: **Communication**

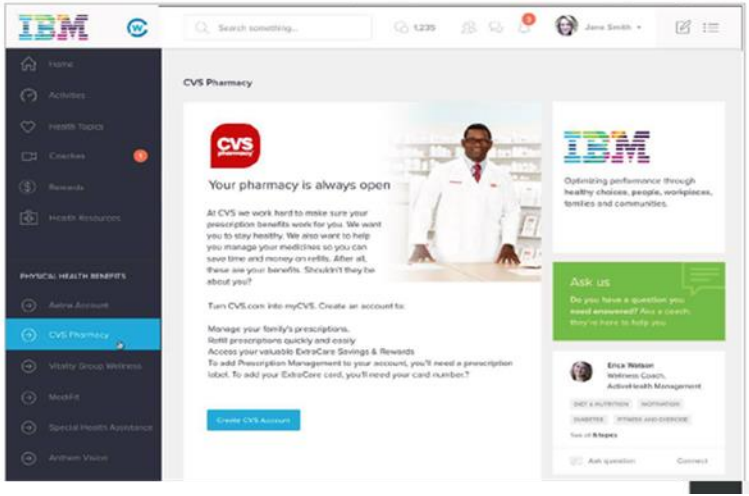
Smart Integration, Customization, and Engagement:

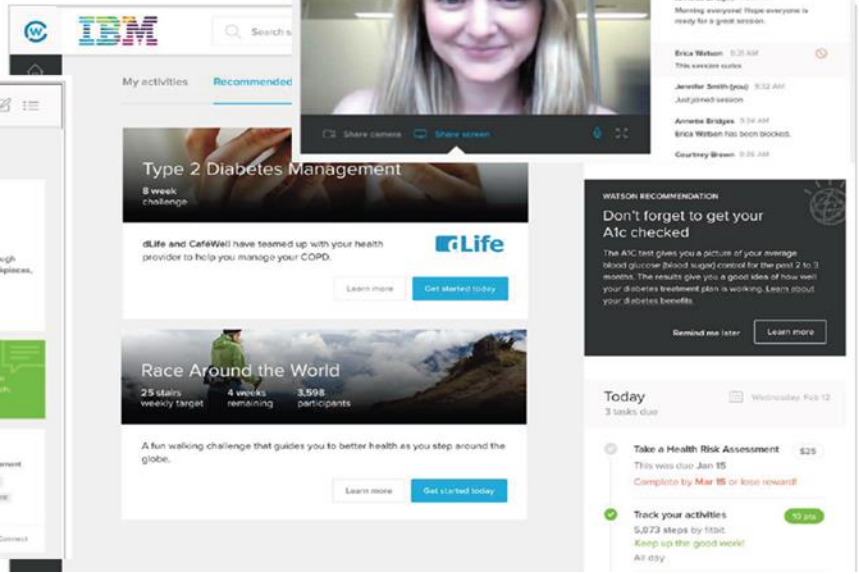
*Improve the **overall health and vitality** of our employees and their families*

5 Dimensions of Health:

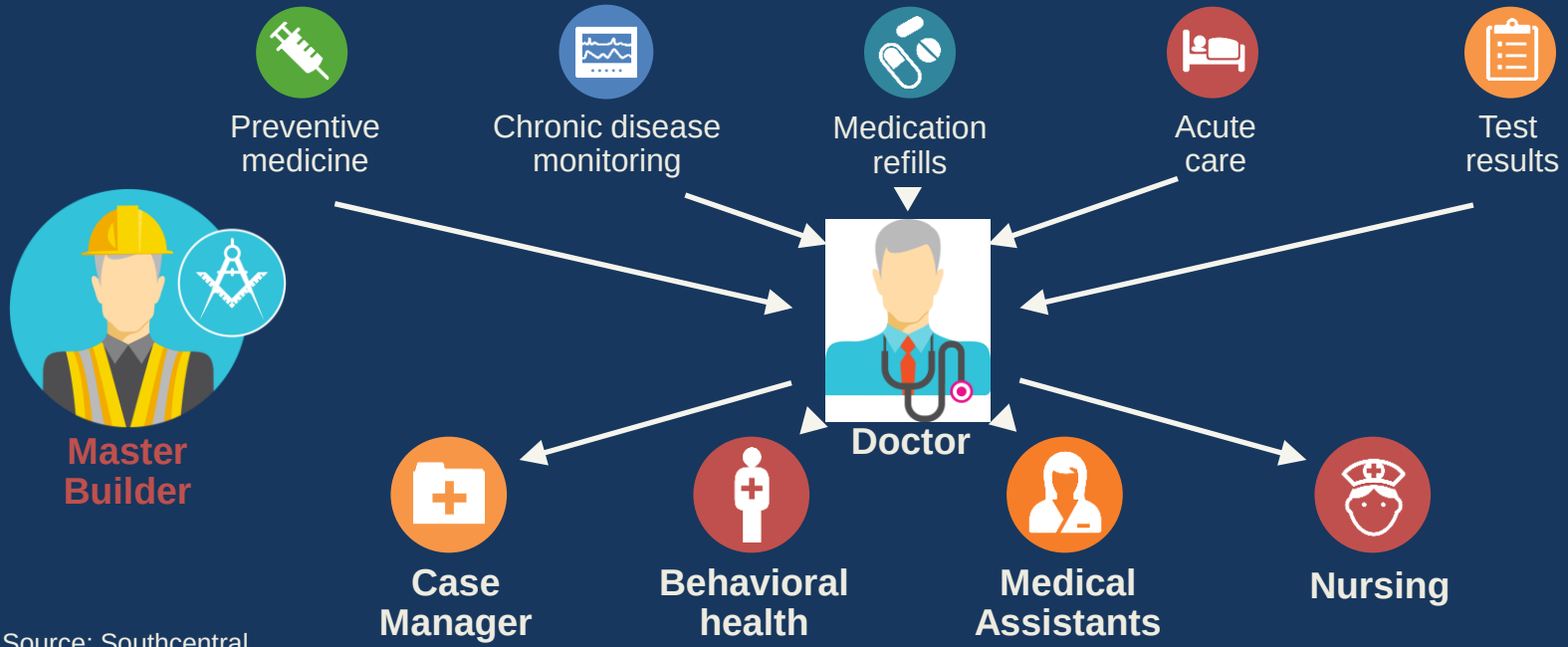
- *Physical*
- *Mental*
- *Financial*
- *Social*
- *Purpose*





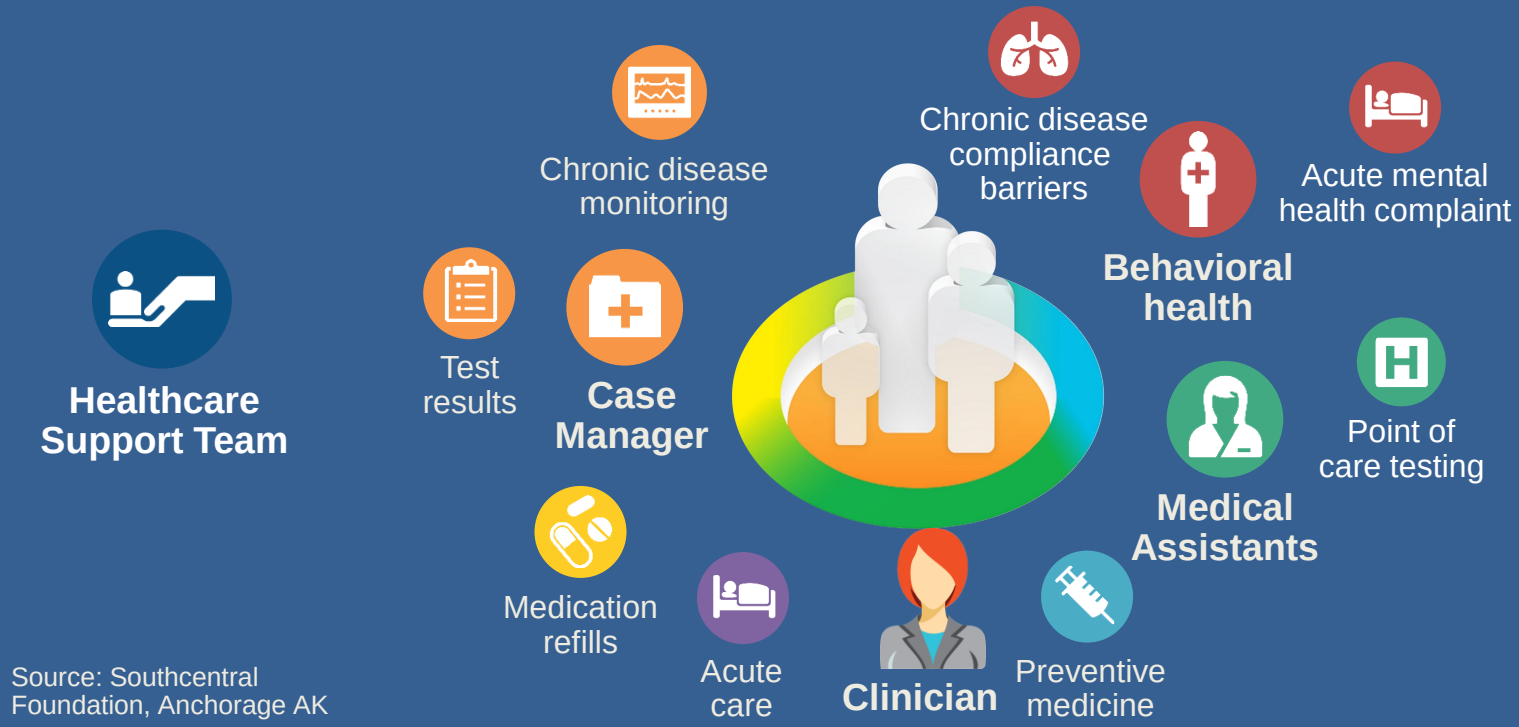


Practice transformation away from episode of care



Source: Southcentral Foundation, Anchorage AK

New model of care – putting the patient first



Source: Southcentral Foundation, Anchorage AK

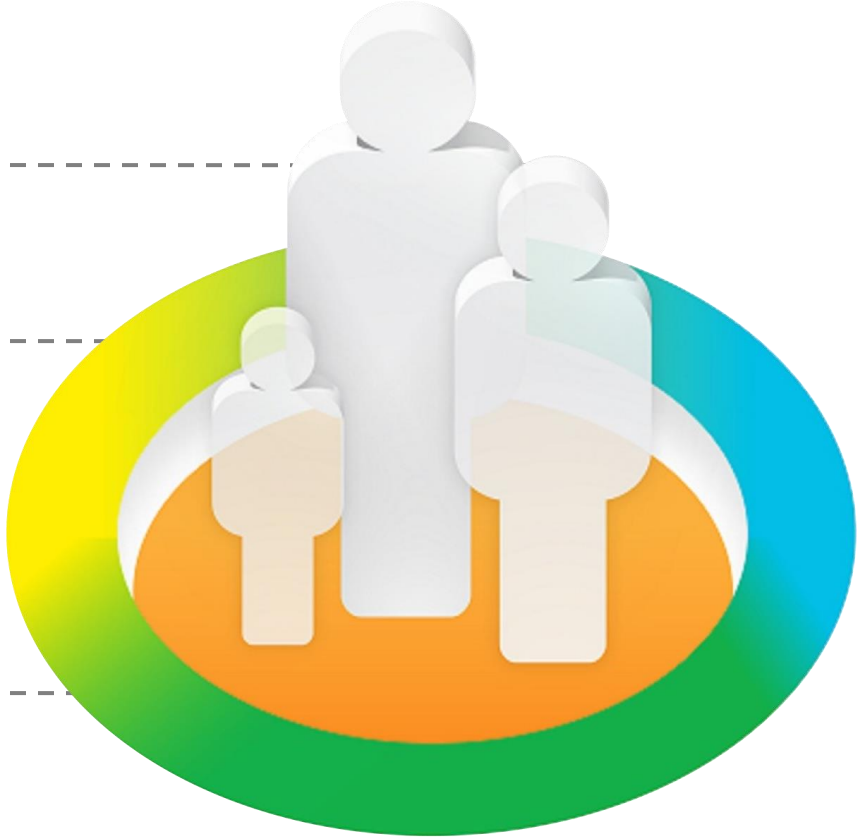
Future healthcare transformation

Data driven

Every person has a plan

Team based

Managing a population down to the individual



MARKET VECTORS

- Medicare value based payments
- ACO
- PCMH
- Bundled Payments
- Payer Programs
- CINs

ENGAGEMENT	• Purpose driven [close care gaps, change behavior, etc.] • Multimodal • Behavioral Sciences
ANALYTICS	• Benchmarking • Reporting / View • Stratify & Predict
DATA	• 360° View of Patient [Data Sources: claims, patient reported, hospital, homecare, devices] • Data model • API (I/O)

Today's Care

PCMH Care

Today's Care	PCMH Care
My patients are those making appointments to see me	Our patients are the population community
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs with or without visits
Care varies by scheduled time and memory/skill of the doctor	Care is standardized according to evidence-based guidelines
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations centre on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients

Source:
Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

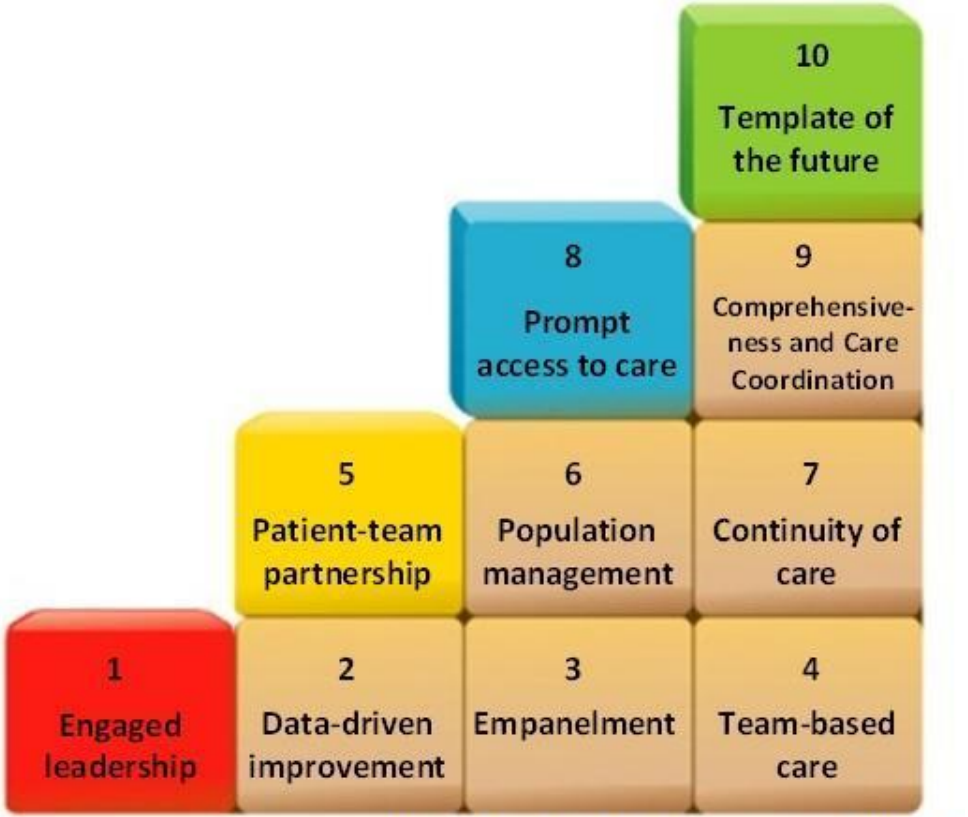
Defining the care centered on the patient

- Superb access to care
- Patient engagement in care
- Clinical information systems, registry
- Care coordination

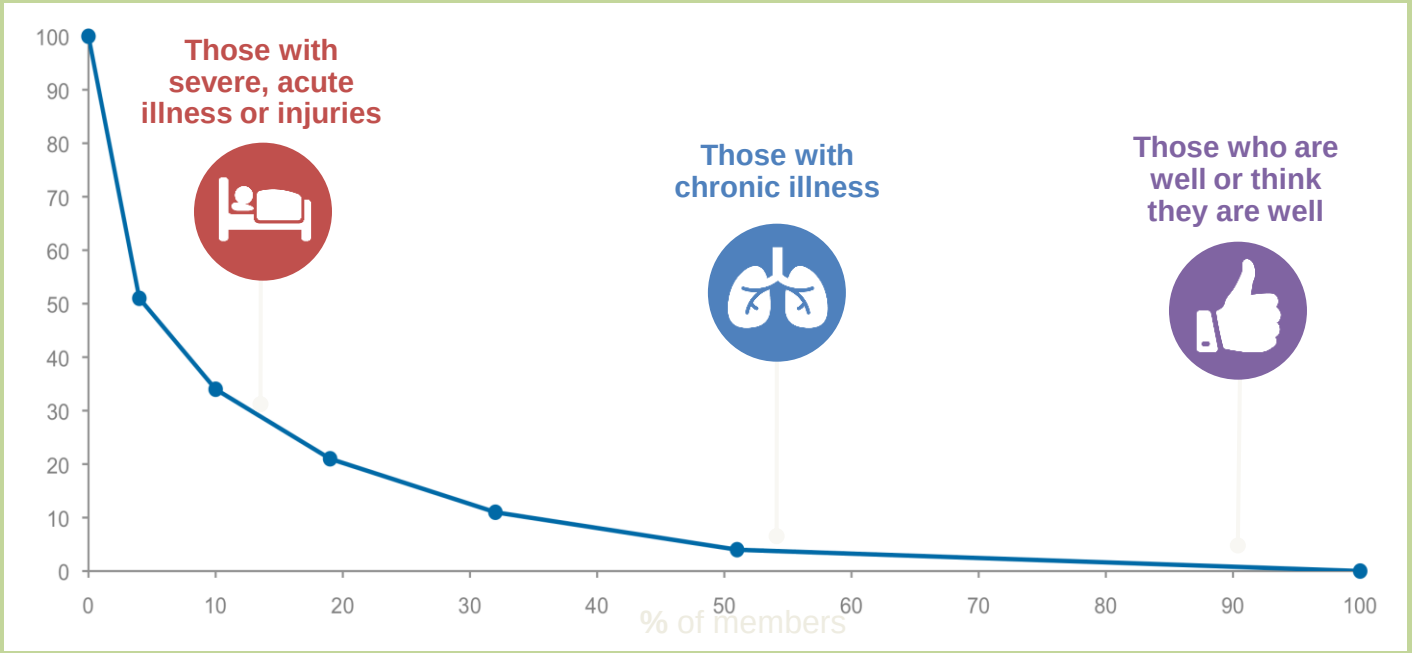
- Team care
- Communication/ Patient Feedback
- Mobile – easy to use and available information

Leadership and engagement: Lighting the fire, fanning the flame

#1 effective and stable leadership
#2 rowing together
#3 the Clinician were excited
#4 meaningful financial support
#5 Including CMS/ state/ Medicaid support
#6 multipayer participation healthcare plans, employers, state, Medicaid, Medicare, HHS.
#7 technical assistance and collaborative learning
#8 team-based approaches that extend beyond the practice
#9 realistic time tables for evaluation
#10 the right tools to be able to get at accessible and useful data.



Benefit redesign – Patient engagement
Different strategies for different Healthcare spend segments

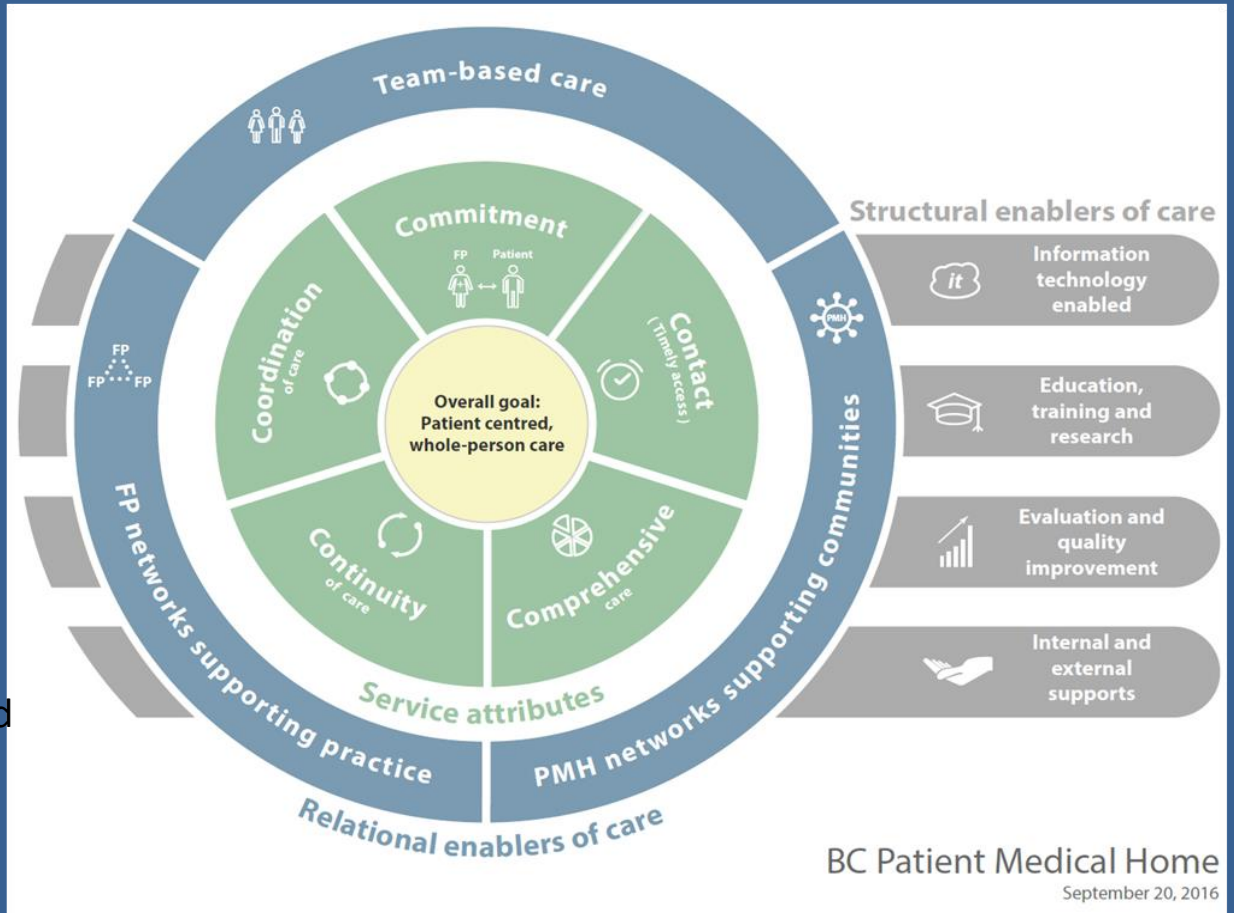


PCMH 2.0 in action

Jersey Post

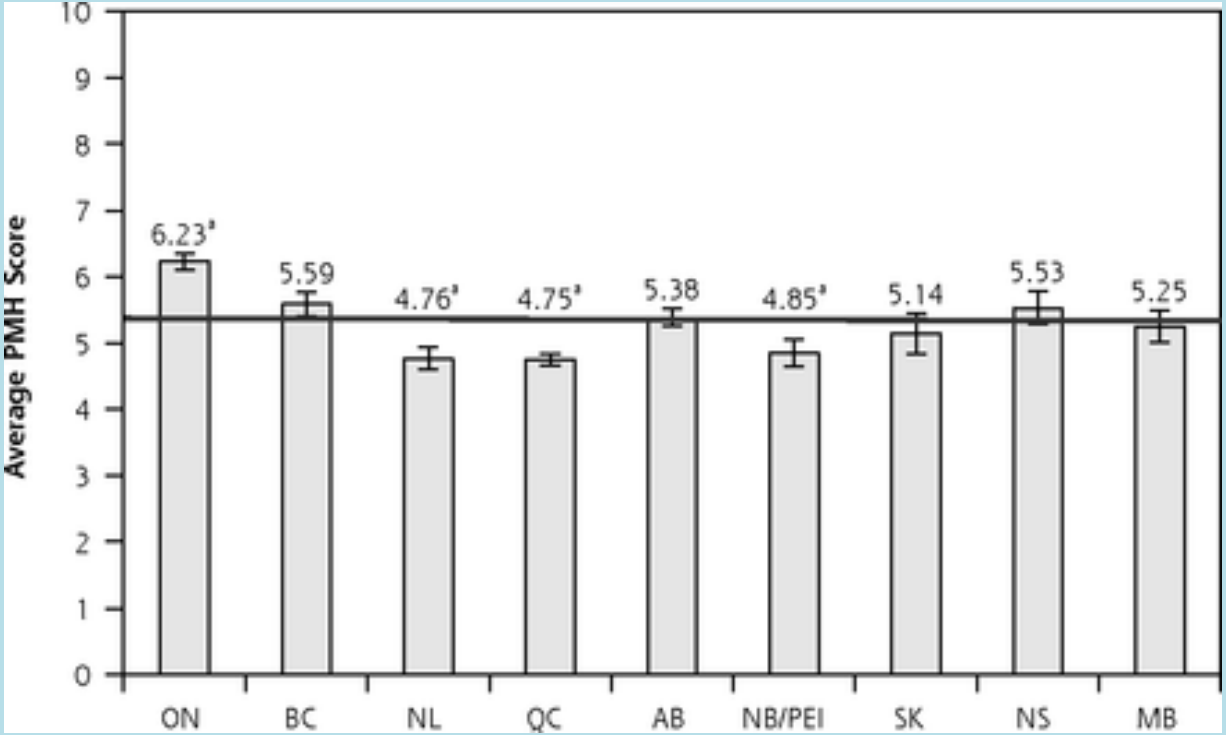
Call & Check Providing support and care for all in the community

12 Attributes of PCH in British Columbia



From Dr Brenda Hefford
Executive Director,
Community Practice,
Quality and Integration

measurable indicators of the PMH model and applied them across 10 Canadian provinces. The national average PMH score was 5.63 of 10, which indicates that major work remains. Ontario was the only province to achieve a higher overall PMH score than the national average.



Alignment of Canadian Primary Care With the Patient Medical Home Model: A QUALICO-PC Study – May 2017

http://www.annfammed.org/content/15/3/230.full

Alignment of Canadian Primary Care With the Patient Medical Home Model The 10 Goals of the Patient Medical Home

1. Patient centered -Provide services that are responsive to patients' and their families' feelings, preferences, and expectations

2. Personal family physician- The most responsible provider of a given patient's medical care Every person in Canada should have a personal family physician

3. Team-based care Offer a broad scope of services carried out by teams or networks of clinicians; inclusive of nurses, peer physicians, and others

4. Timely access Timely access to appointments in the practice Advocate for and coordinate timely appointments with other health and medical services required

5. Comprehensive care Provide a comprehensive scope of family practice services by working collaboratively with other professionals Address public health needs Taking population health effects into account

6. Continuity Offer continuous care over time and in different settings Advocate on the patients' behalf for continuity of care throughout the health care system Preserve constant relationships and continuous medical information for patients

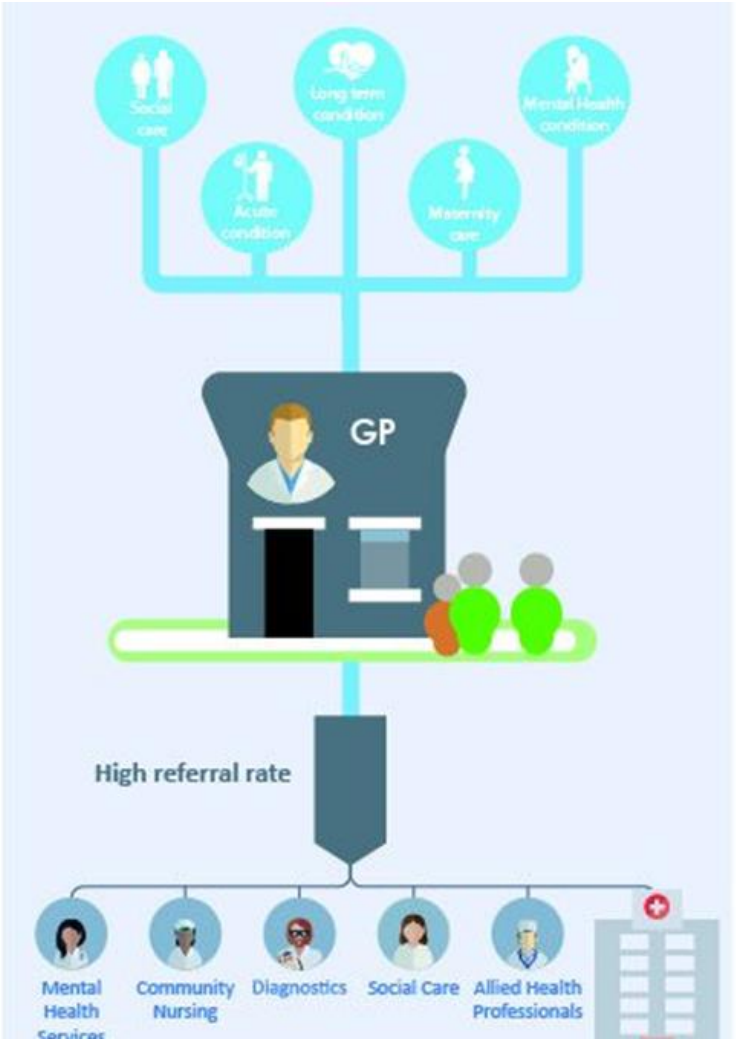
7. Electronic records and health information Maintain electronic medical records

8. Education, training, and research Serve as a model place for training students, residents, and other health professionals Carry out and/or encourage staff to be involved in primary care research

9. Evaluation Carry out ongoing evaluation as part of the commitment to continuous quality improvement

10. System support Internal support through governance and management structures External support by stakeholders, the public, and other medical and health professionals and their organizations across Canada

English Primary Care Homes



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