



A Reason to Celebrate PCMH

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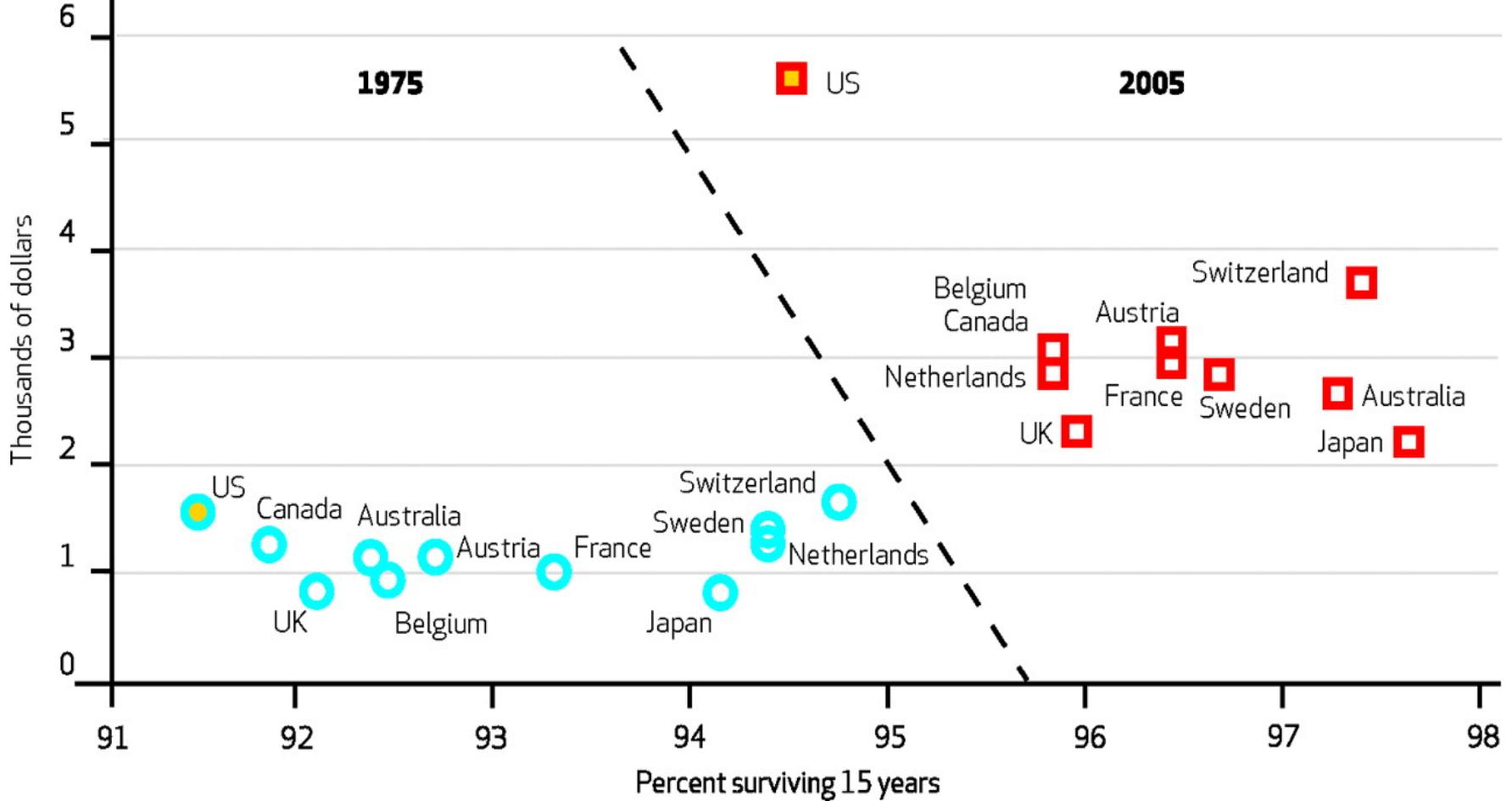
Patient Centered
PRIMARY CARE
Collaborative

Patient Centered Medical Home VS Body Parts for Cash

Treat your Care Needs like a **BAD MEDICAL NEIGHBORHOOD!!** Unaccountable care, lack of organization do not go there alone -- Be wise turn the \$2.7 Trillion around towards PCMH Robust Primary care prevention !!

It is killing us and our Children





The Cause is clear - **unregulated fee-for-service payments and an over reliance on rescue/specialty care.**

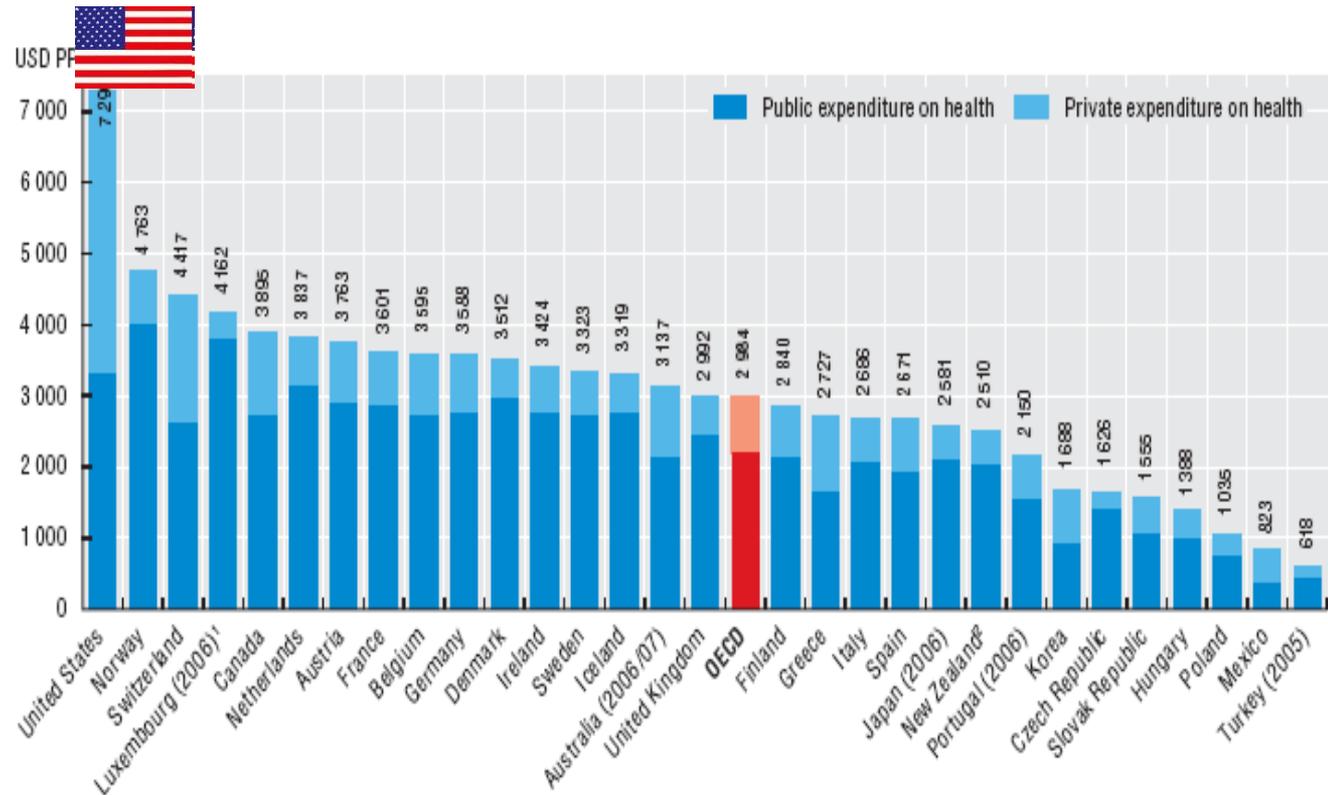
This study provides stark evidence that the U.S. health care system has been failing Americans for years,“

Commonly cited causes for the nation's poor performance are not to blame

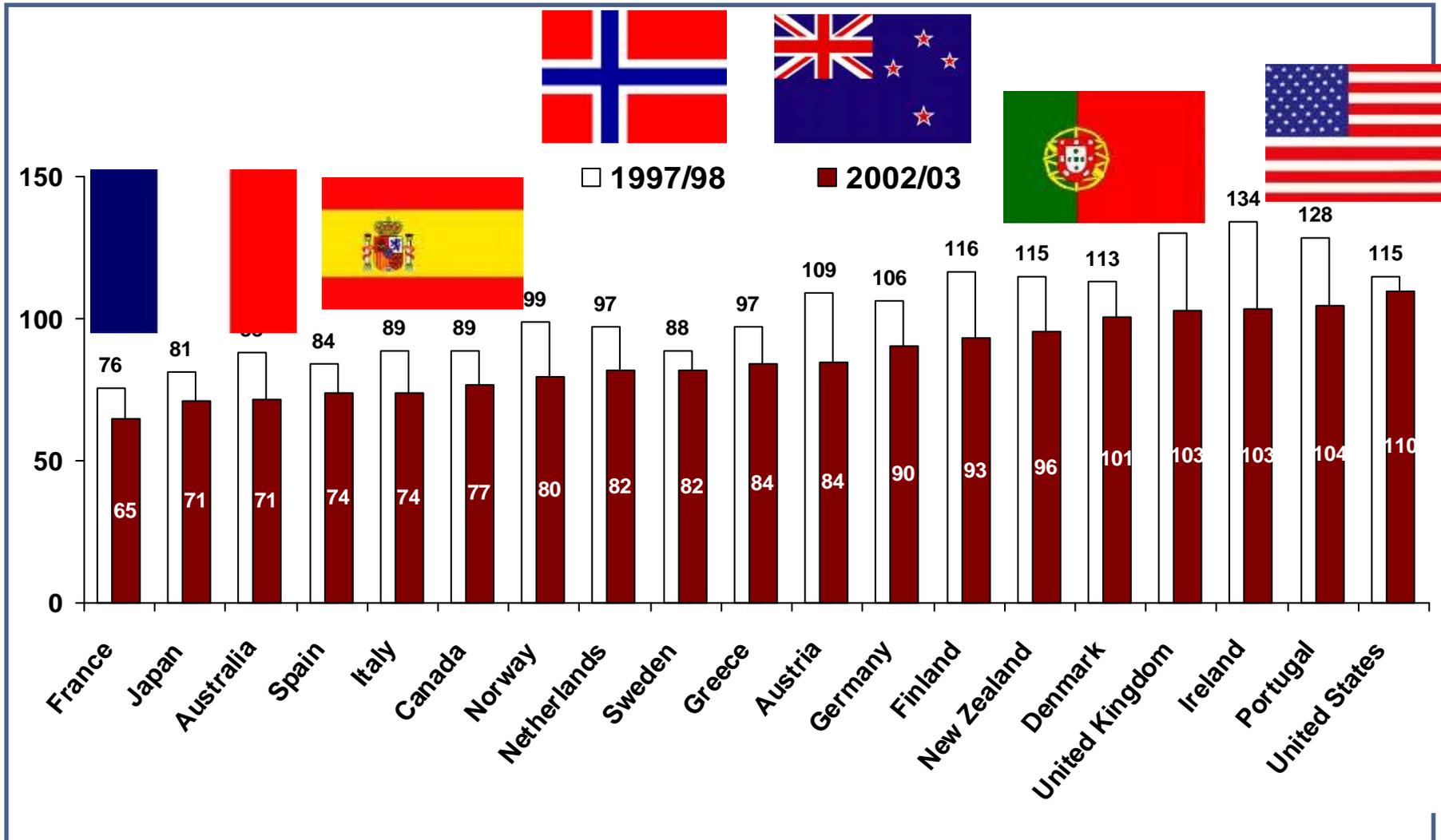
How do you fix the foundational issue: our healthcare system is so High Cost and yet so low value ??

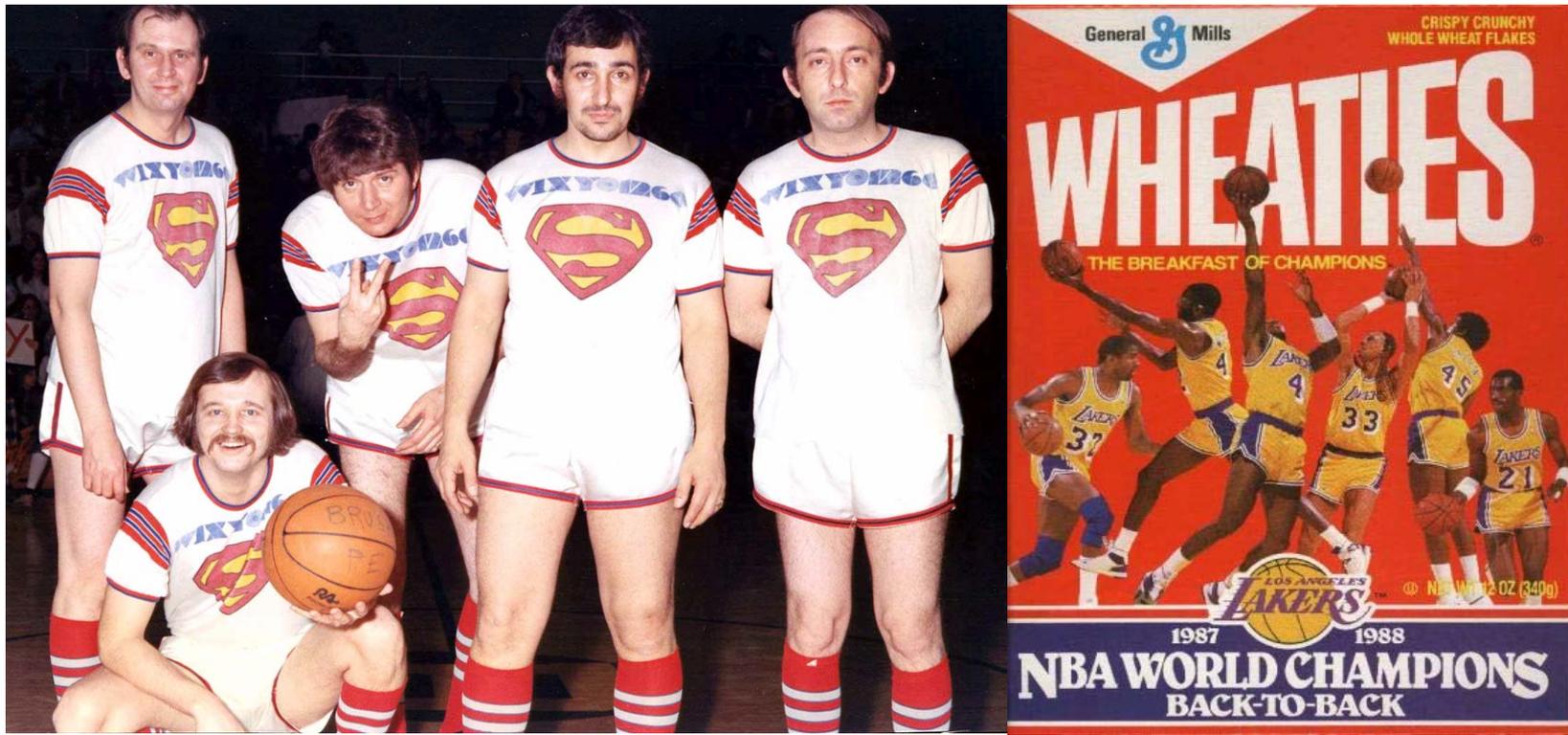


Average health spend per capita (\$US PPP)



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





Coordination -- 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 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*”

Patient Centered Medical Home

The HUB President Obama 06/08/2010

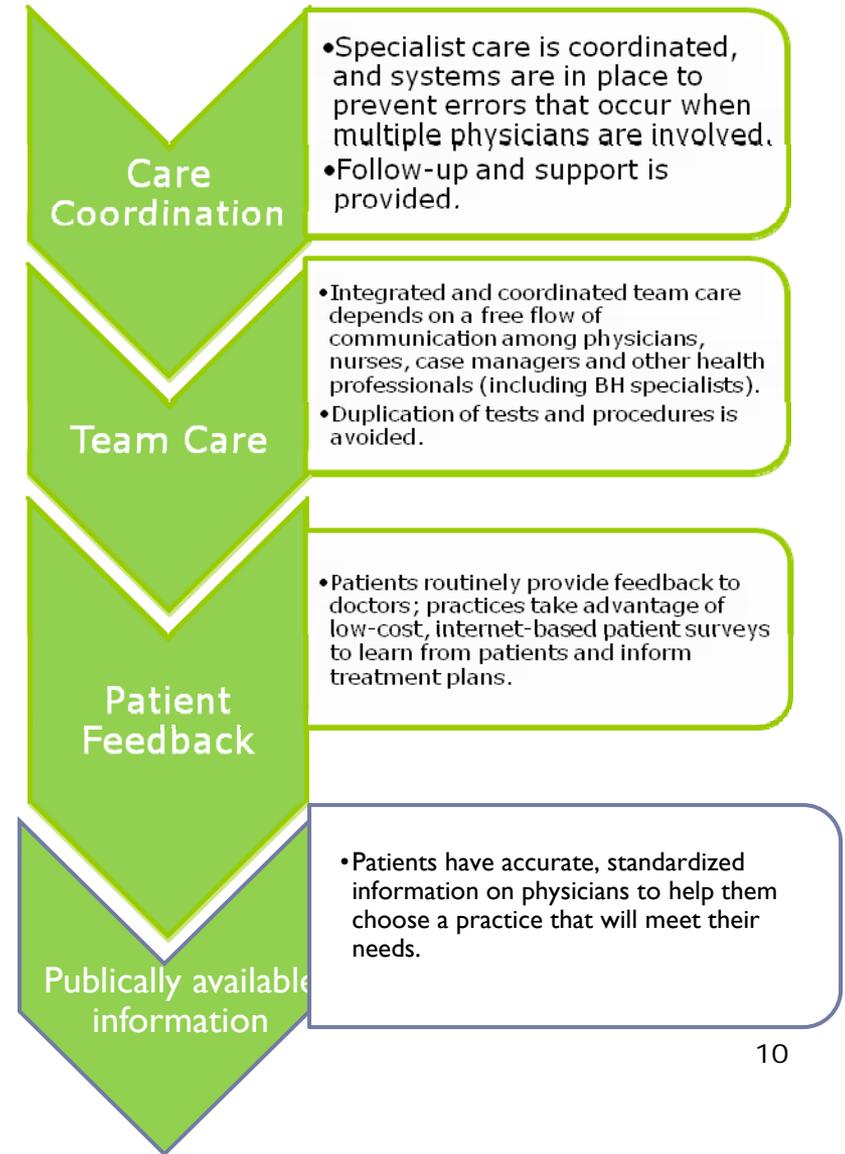
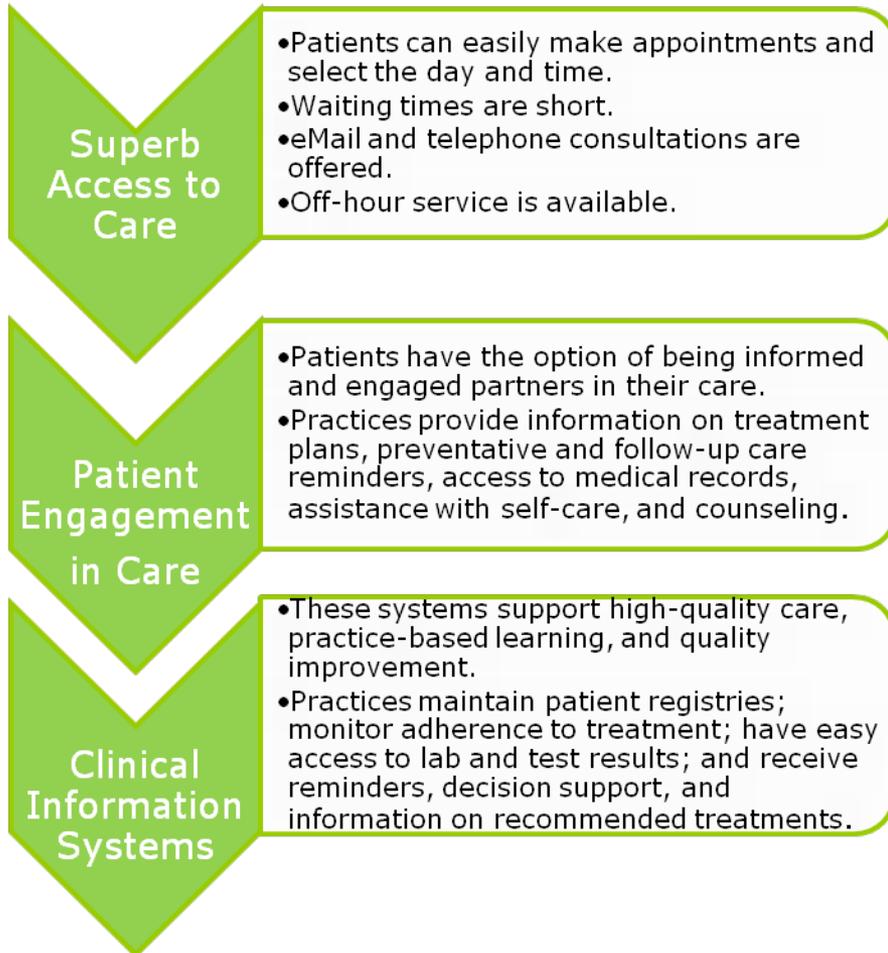


A long-term **comprehensive** relationship with your Personal Physician **empowered with the right tools** and linked to your care team can result in better overall family health...

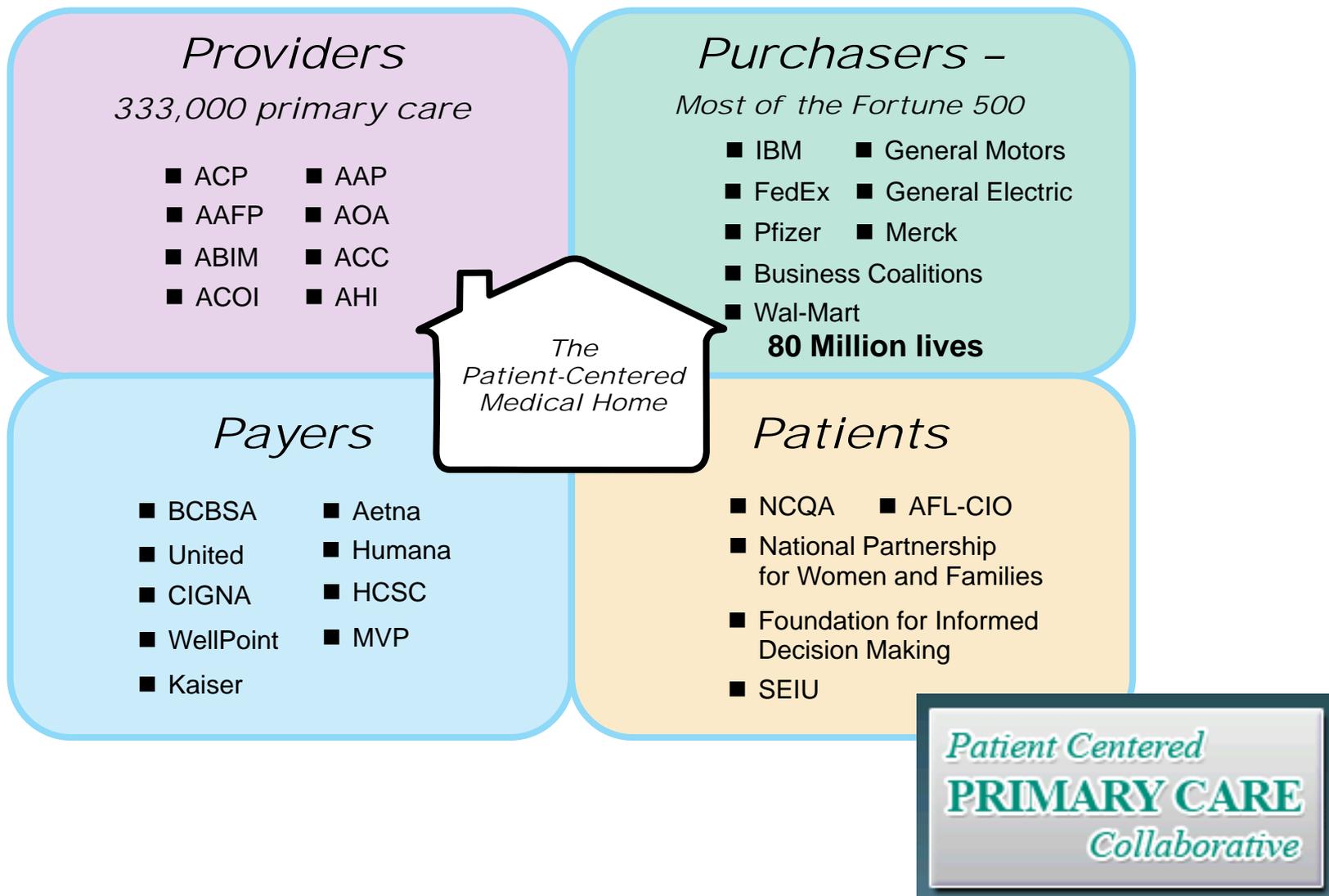
The Joint principles Patient Centered Medical Home

- ▶ **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

Defining the Care



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

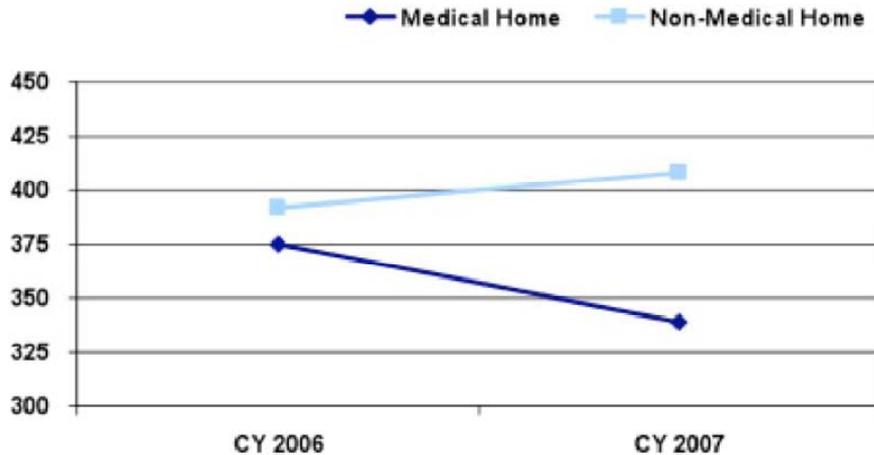


Geisinger Health System



Geisinger Medical Home Sites and Hospital Admissions

Hospital admissions per 1,000 Medicare patients



Lewisburg Penn	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			9% less

Source: Geisinger Health System, 2008.

Moving towards a more accountable coordinated system

