Strengthening and Transforming Primary Care

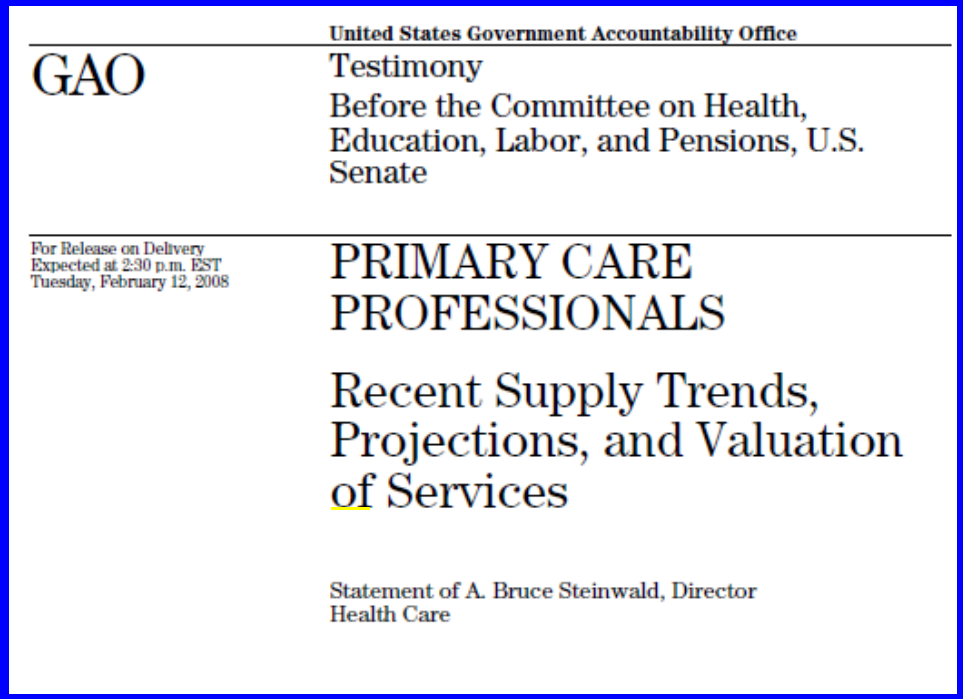
Grantmakers in Health Webinar
October 18, 2011

Kevin Grumbach, MD

Center for Excellence in Primary Care

Department of Family & Community Medicine

University of California, San Francisco



United States Government Accountability Office

GAO

Testimony
Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

For Release on Delivery
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Tuesday, February 12, 2008

PRIMARY CARE PROFESSIONALS

Recent Supply Trends, Projections, and Valuation of Services

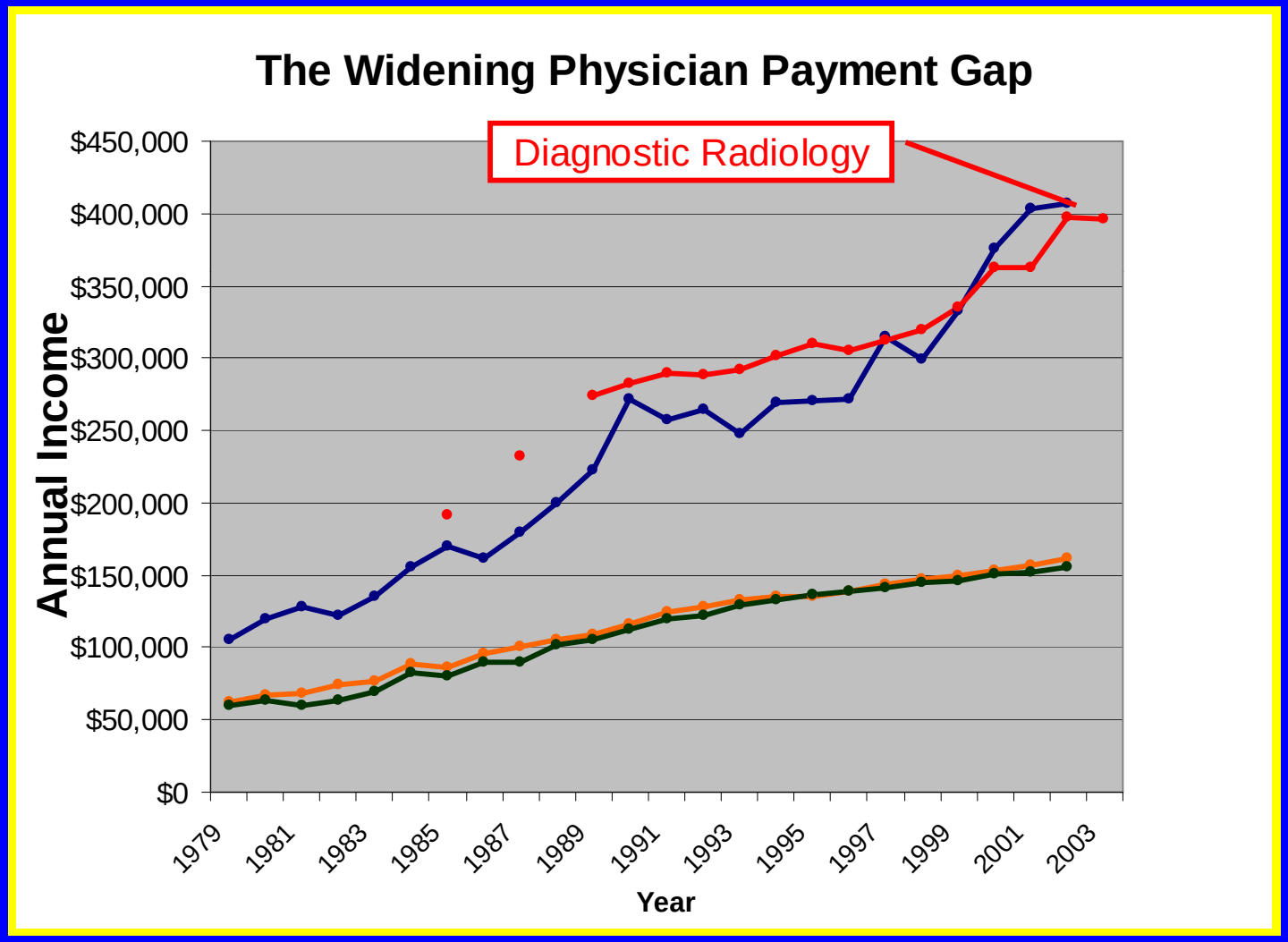
Statement of A. Bruce Steinwald, Director
Health Care

"Ample research concludes in recent years that the nation's over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient…research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings."

But the Primary Care Foundation in the US is Crumbling

- Plummeting numbers of new physicians entering primary care and burnout among PCPs
- Growing problems of access to primary care and "medical homelessness"
- Dysfunctional systems that are not delivering the goods in primary care

Partly a Payment Issue



Partly a Systems Issue

- A primary care physician with a panel of 2500 average patients would spend:
  - 7.4 hours per day to deliver all recommended preventive care (Yarnall et al. Am J Public Health 2003;93:635)
  - 10.6 hours per day to deliver all recommended chronic care services (Ostbye et al. Annals of Fam Med 2005;3:209)

Randy MacDonald, Sr VP

House Ways and Means Hearing April 29, 2009

- "I will start with the very last question asked by the committee--what is the single most important thing to fix in healthcare? Primary care. Strengthen primary care -- transform it and pay differently using a model like the Patient Centered Medical Home."
- Congressman: "And the second issue?"
- "Well, if you don't fix the first issue and do not have a foundation of powerful primary care then you can do nothing else. You have to fix primary care before you can even begin to address a second issue."

The Multistakeholder Movement for Renewal and Reform of Primary Care

- Large employers/private purchasers
- Consumers/patients/the public
- Government
- Health professionals

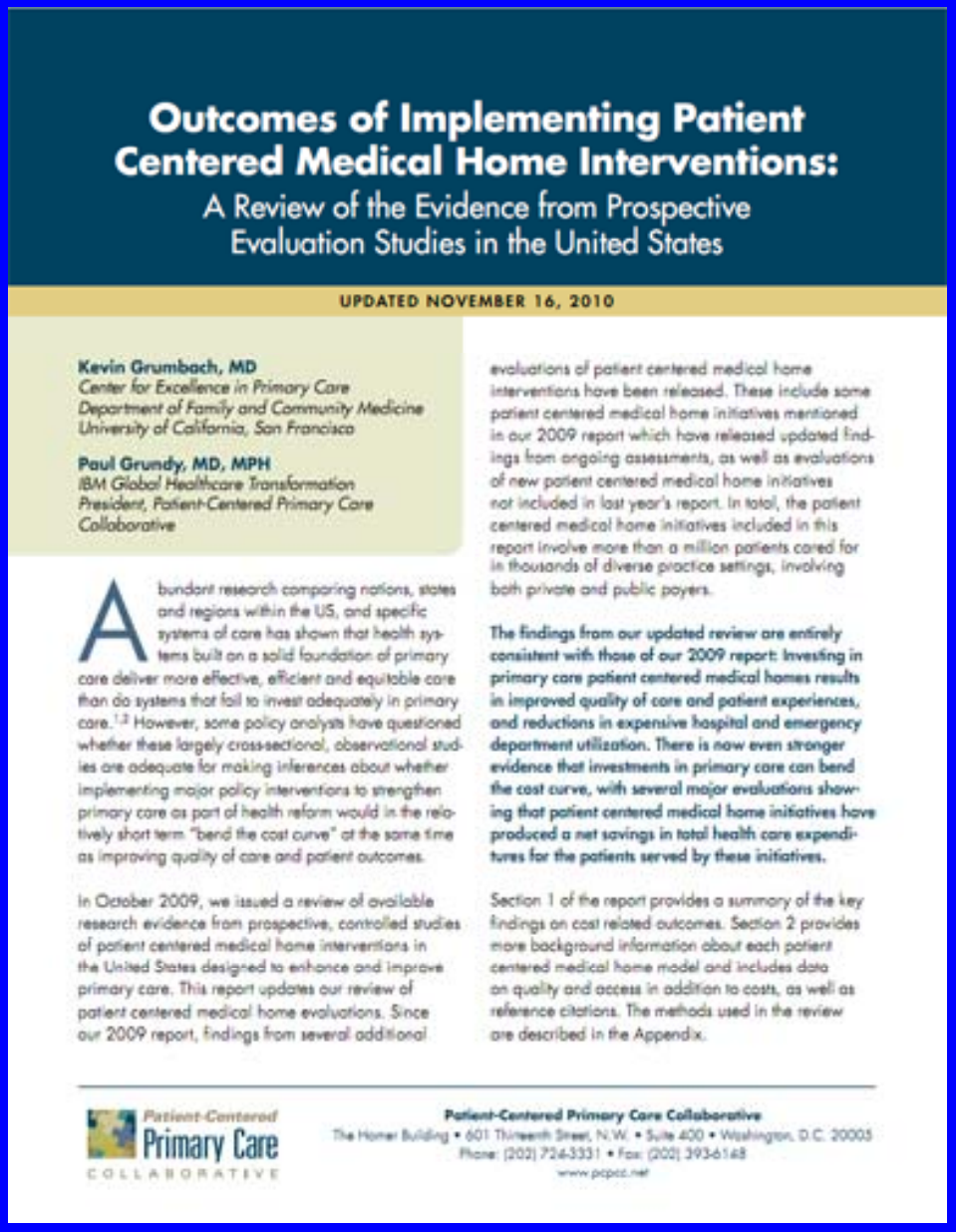
Transforming the Delivery of Primary Care: The Patient Centered Medical Home

- Rittenhouse & Shortell: 4 Cornerstones of the PCMH
- Primary Care
  - first Contact (access)
  - Comprehensiveness
  - Continuity
  - Coordination
- Patient-Centered
- New Model Practice
- Payment Reform

Old School vs New School Primary Care

Today's care	Medical home care
My patients are those who make appointments to see me	Our patients are those who are registered in our medical home
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies by scheduled time and memory or 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 works with all patients to coordinate care
It's up to the patient to tell us what happened to them	We track tests and consultations, and follow-up after ED and hospital
Clinic operations center on meeting the doctor's needs	An interdisciplinary team works at the top of our licenses to serve patients

Source: Adapted with permission from F. Daniel Duffy, MD, MACP, Senior Associate Dean for Academics, University of Oklahoma School of Community Medicine.



Outcomes of Implementing Patient Centered Medical Home Interventions:

A Review of the Evidence from Prospective Evaluation Studies in the United States

UPDATED NOVEMBER 16, 2010

Kevin Grumbach, MD
Center for Excellence in Primary Care
Department of Family and Community Medicine
University of California, San Francisco

Paul Grundy, MD, MPH
IBM Global Healthcare Transformation
President, Patient-Centered Primary Care Collaborative

Abundant research comparing nations, states and regions within the US, and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient and equitable care than do systems that fail to invest adequately in primary care.[1,2] However, some policy analysts have questioned whether these largely cross-sectional, observational studies are adequate for making inferences about whether implementing major policy interventions to strengthen primary care as part of health reform would in the relatively short term "bend the cost curve" at the same time as improving quality of care and patient outcomes.

In October 2009, we issued a review of available research evidence from prospective, controlled studies of patient centered medical home interventions in the United States designed to enhance and improve primary care. This report updates our review of patient centered medical home evaluations. Since our 2009 report, findings from several additional evaluations of patient centered medical home interventions have been released. These include some patient centered medical home initiatives mentioned in our 2009 report which have released updated findings from ongoing assessments, as well as evaluations of new patient centered medical home initiatives not included in last year's report. In total, the patient centered medical home initiatives included in this report involve more than a million patients cared for in thousands of diverse practice settings, involving both private and public payers.

The findings from our updated review are entirely consistent with those of our 2009 report: Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization. There is now even stronger evidence that investments in primary care can bend the cost curve, with several major evaluations showing that patient centered medical home initiatives have produced a net savings in total health care expenditures for the patients served by these initiatives.

Section 1 of the report provides a summary of the key findings on cost related outcomes. Section 2 provides more background information about each patient centered medical home model and includes data on quality and access in addition to costs, as well as reference citations. The methods used in the review are described in the Appendix.

Patient-Centered Primary Care COLLABORATIVE

Patient-Centered Primary Care Collaborative
The Homer Building • 601 Thirteenth Street, N.W. • Suite 400 • Washington, D.C. 20005
Phone: (202) 724-3331 • Fax: (202) 3936168
www.pcpcc.net

http://www.pcpcc.net/content/pcmh-outcome-evidence-quality

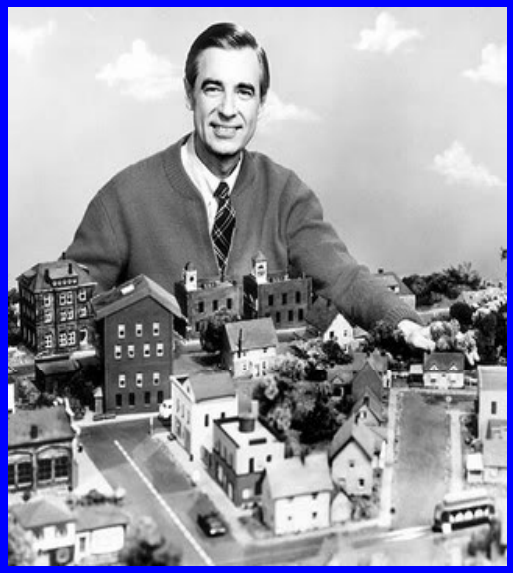
Review of Recent Evidence on PCMH Outcomes

- 14 different initiatives
  - >1 million patients, 1000s of medical practices
  - 5 Integrated delivery systems
    - Group Health, Geisinger, HealthPartners, Intermountain, VHA
  - 3 Private health plan sponsored initiatives
    - BCBS South Carolina, BCBS North Dakota, Metropolitan Health Networks Florida
  - 2 Medicaid state initiatives
    - North Carolina, Colorado
  - 4 Other models

Examples of Cost Outcomes

- Group Health Cooperative: 5% ↓ $PMPM
- Geisinger: 7% ↓ $PMPM
- VA: $593 ↓ cost per patient with COPD
- BCBS South Carolina: 6.5% ↓ $PMPM
- Metropolitan Health Networks: 20% ↓ $ per patient
- North Carolina Medicaid/SCHIP: Cumulative savings of $974.5 million over 6 years (2003-2008)
- Colorado Medicaid: $215 ↓ cost per child per year

From Medical Homes to Medical Neighborhoods



- High performing primary care necessary but not sufficient
- Concept of "Accountable Care Organizations"
  - True integrated delivery systems (Kaiser, Intermountain Health, VA)
  - Virtual organizations: functional integration

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

DECEMBER 10, 2009

Primary Care and Accountable Care — Two Essential Elements of Delivery-System Reform

Diane R. Rittenhouse, M.D., M.P.H., Stephen M. Shortell, Ph.D., M.P.H., M.B.A., and Elliott S. Fisher, M.D., M.P.H.

Michael Pollan's Guide to Nutrition

- Eat food
- Not too much
- Mostly plants

Kevin's Guide to Health Care

- Get medical care
- Not too much
- Mostly primary care