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PCMH Congress™

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San Diego Convention Center

San Diego, CA

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PCMH as the Foundation for Global Health Care Transformation

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Faculty Disclosure

- **Paul Grundy MD, MPH Is a full time employee of the NFP Healthteamworks** otherwise has no financial relationships to disclose relating to the subject matter of this presentation.

Disclosure

- The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the U.S. Food and Drug Administration).
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  - This activity has been independently reviewed for balance.

Learning Objectives

- Understand how PCMH concept is spreading globally with examples
- Learn about some of the differences and variations around the world

WELCOME

Paul Grundy MD, MPH

HealthTeamWorks

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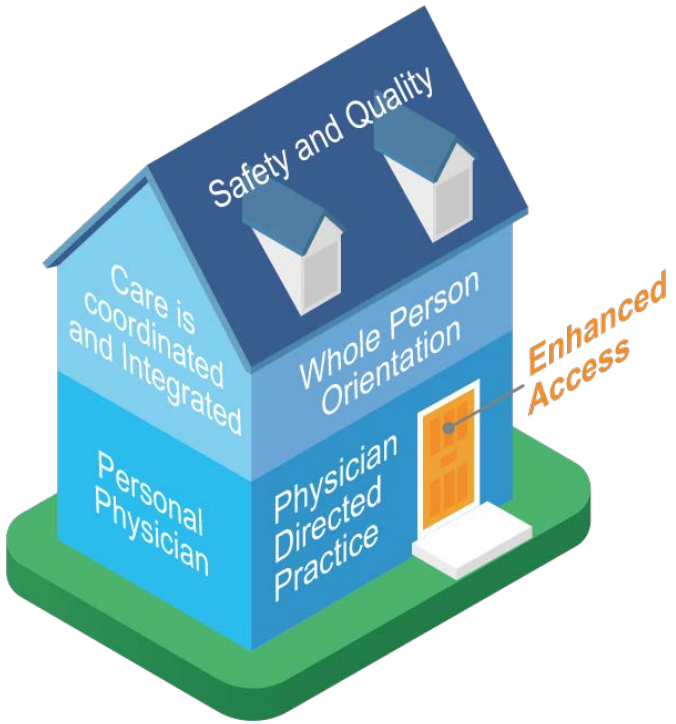
@Paul_PCMH

PCMH A Foundation for Transformation Globally

Away from Episode of Care to Management of Population with Data



The System Integrator

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

Smarter Healthcare

36.3% Drop in hospital days

32.2% Drop in ER use

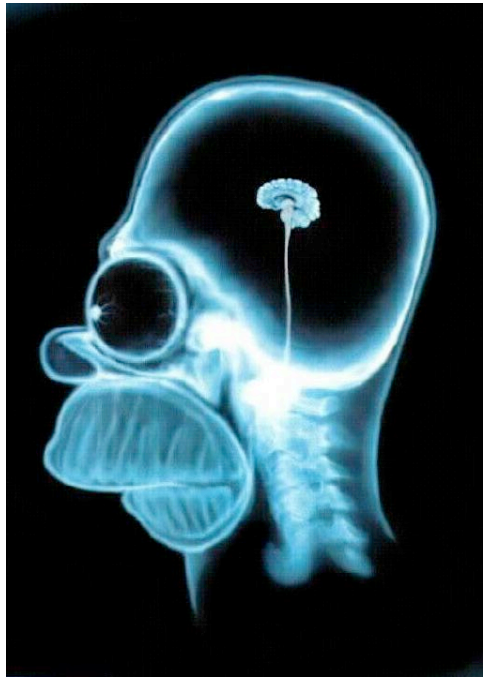
12.8% Increase in chronic medication

-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)

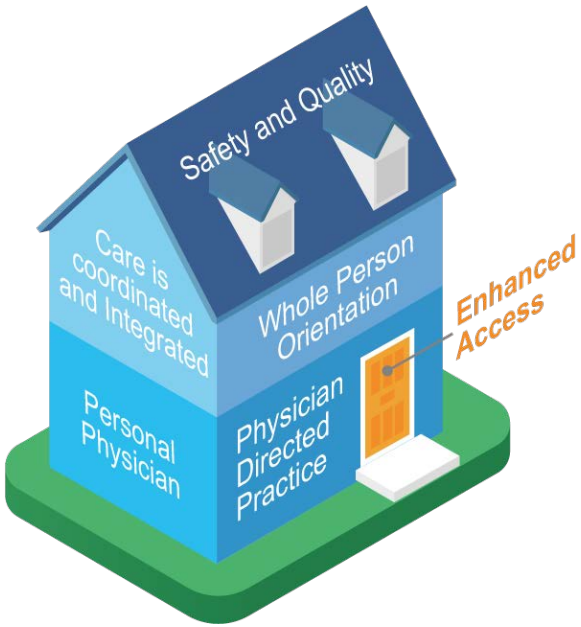
Michigan patient-centered medical home (PCMH) program

Program showed statewide transformation of care.

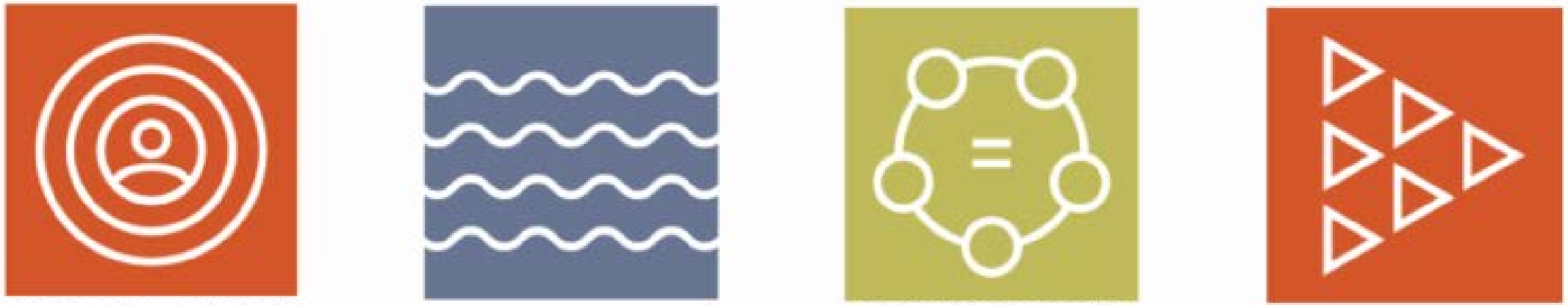
9.9%	Decrease in adult ER visits
27.5%	Decrease in adult ambulatory care sensitive inpatient stays
11.8%	Decrease in adult primary care sensitive ER visits
8.7%	Decrease in adult high-tech radiology usage
14.9%	Decrease in pediatric ER visits
21.3%	Decrease in pediatric primary-care sensitive ER visits

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. Currently in year 10; 14 June 2018.

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 & 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.


PERSON & FAMILY CENTERED
CONTINUOUS
COMPREHENSIVE & EQUITABLE
TEAM BASED & COLLABORATIVE
Shared Principles of Primary Care
COORDINATED & INTEGRATED
ACCESSIBLE
HIGH VALUE

Association between elements of the PCMH model & clinical quality in the Veterans Health Administration

Nelson K, Sylling PW, Taylor L, Rose D, Mori A, Fihn SD. Clinical Quality and the Patient-Centered Medical Home. JAMA *Intern Med.* 2017;177(7):1042–1044. doi:10.1001/jamainternmed.2017.0963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Payment reform requires more than one dial

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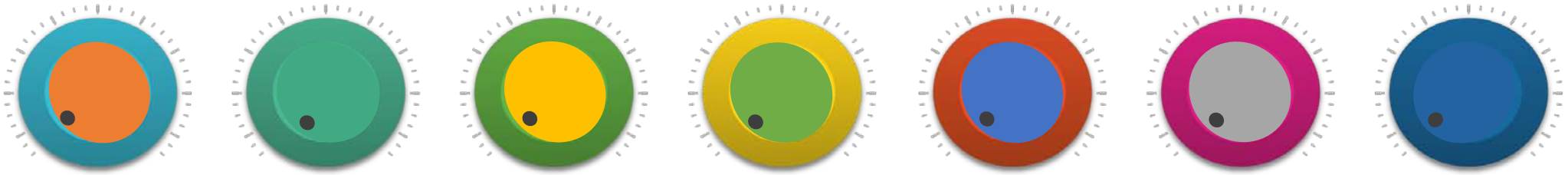
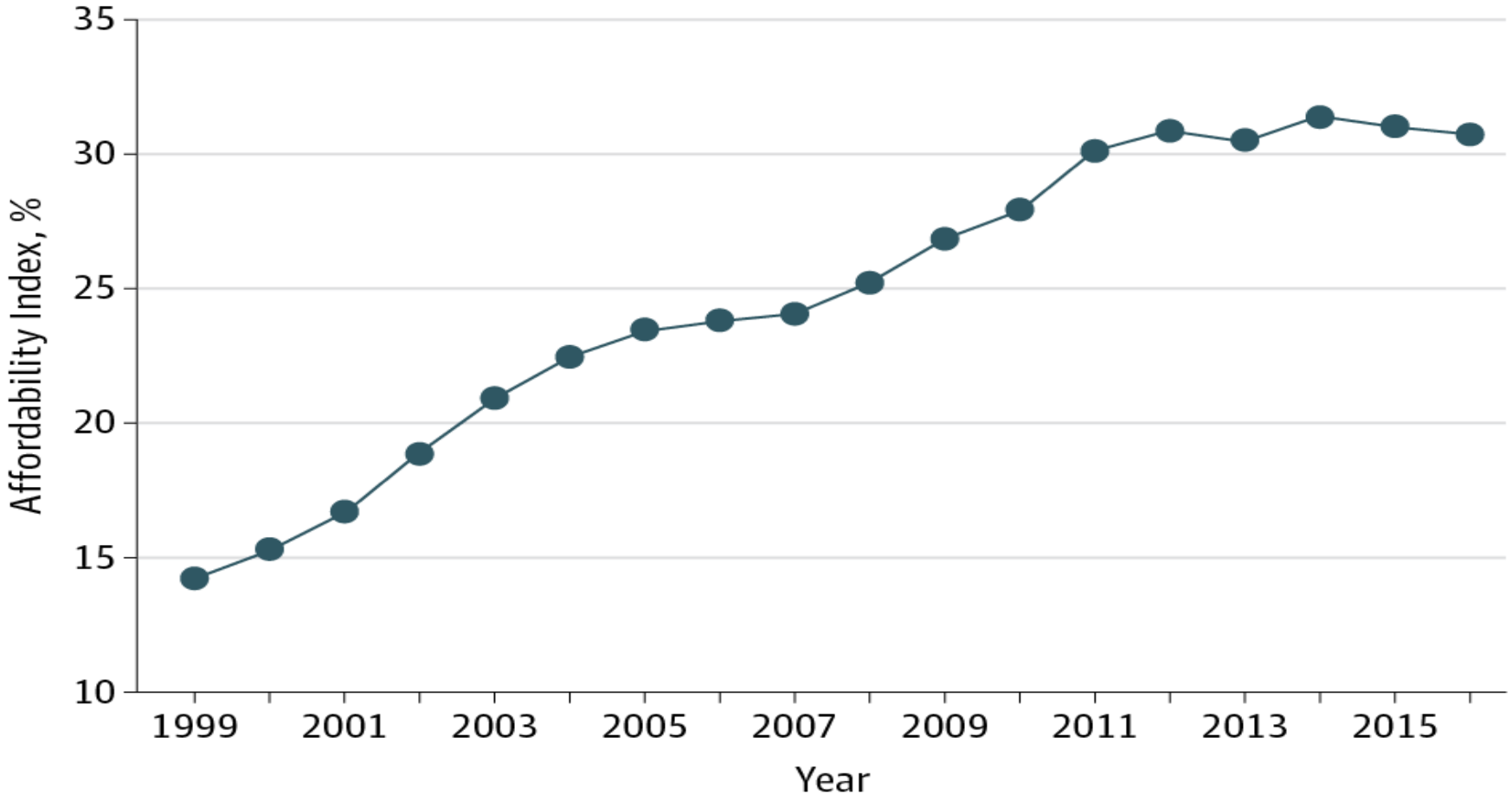


health | value | outcome | process | belonging | service | satisfaction

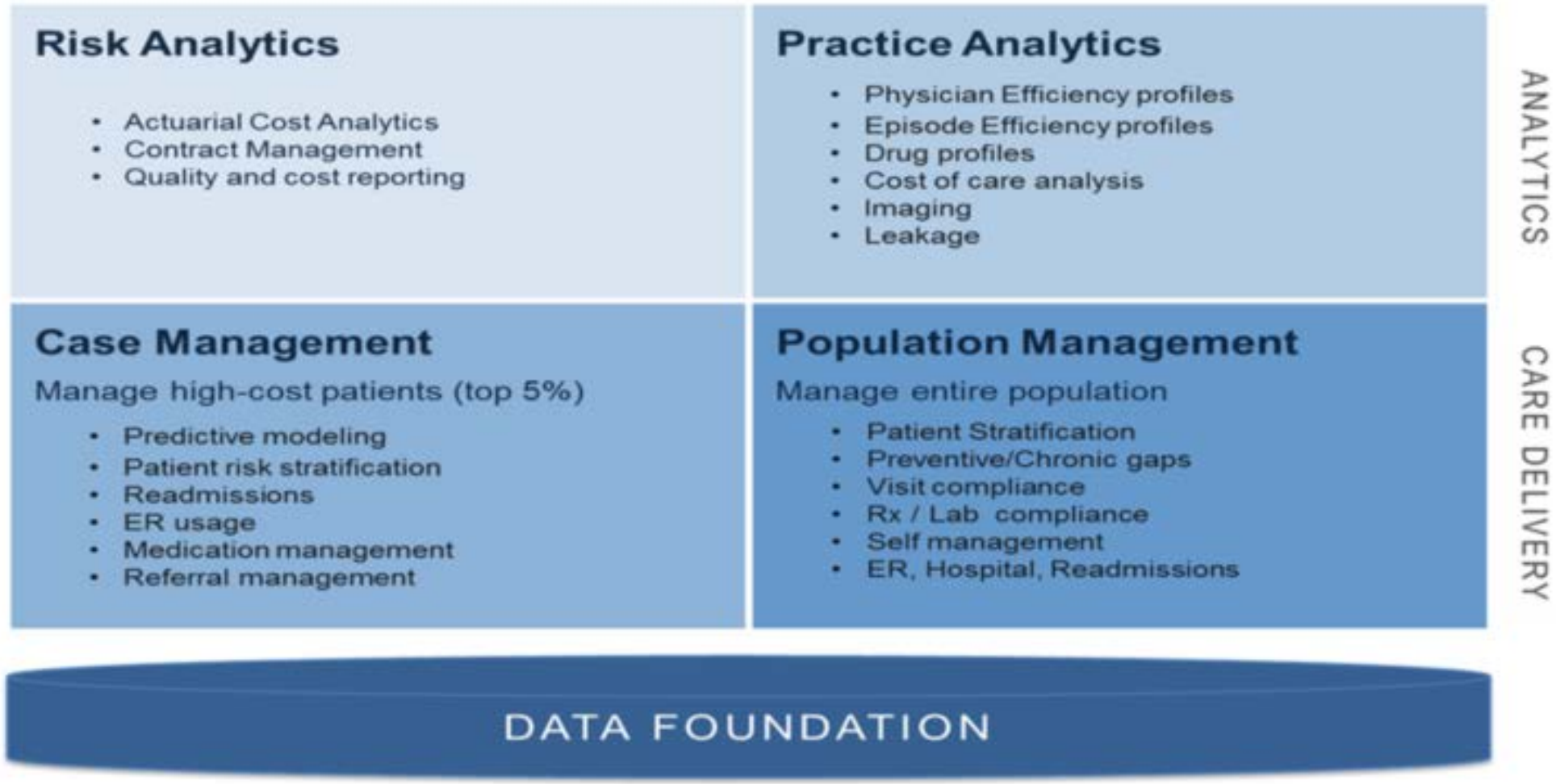
Driving factor 1: Unsustainable Cost

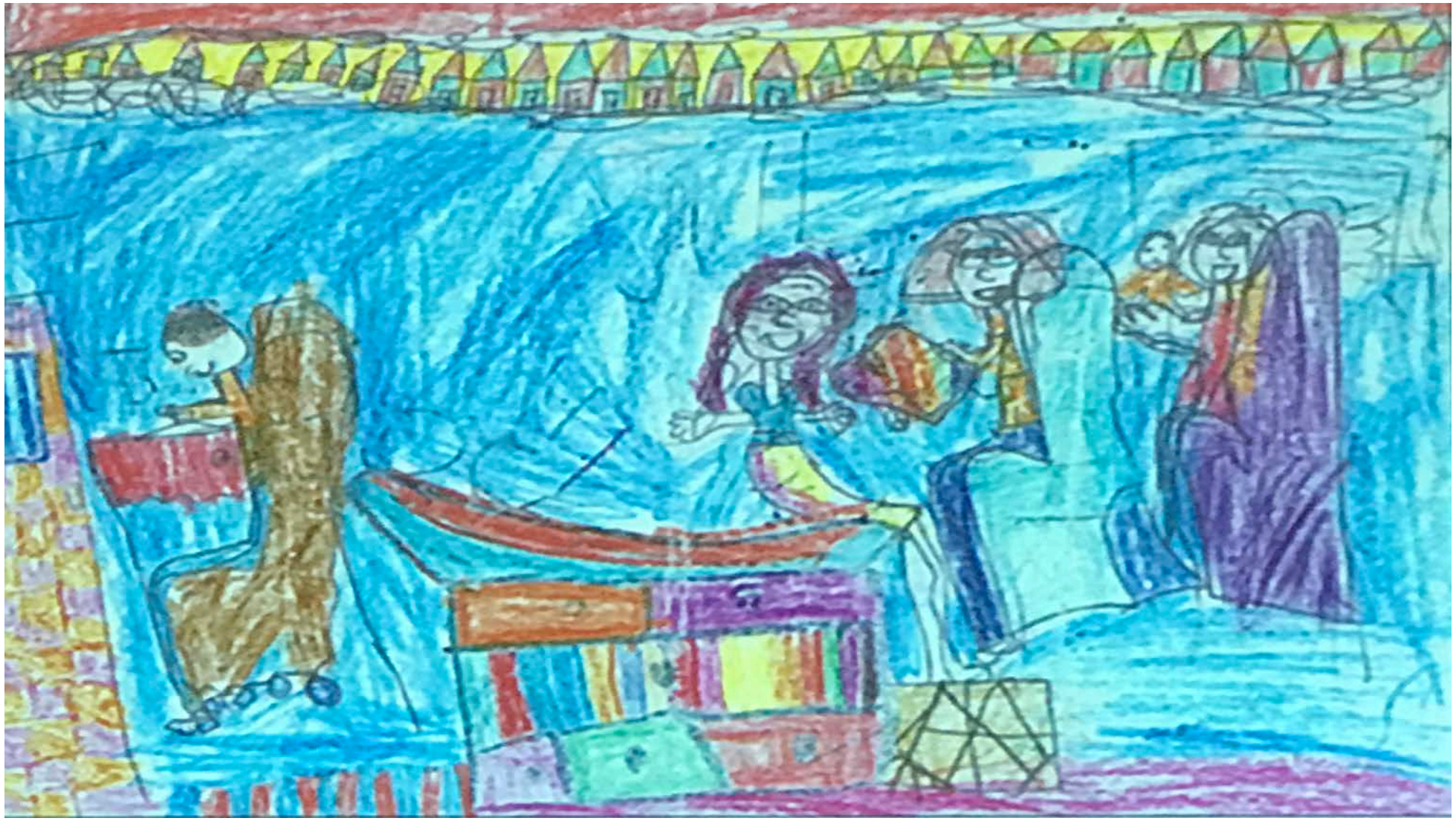
Unsustainable Cost (USA, 2017)



Driving factor 2: Data

Value-Based Care Components



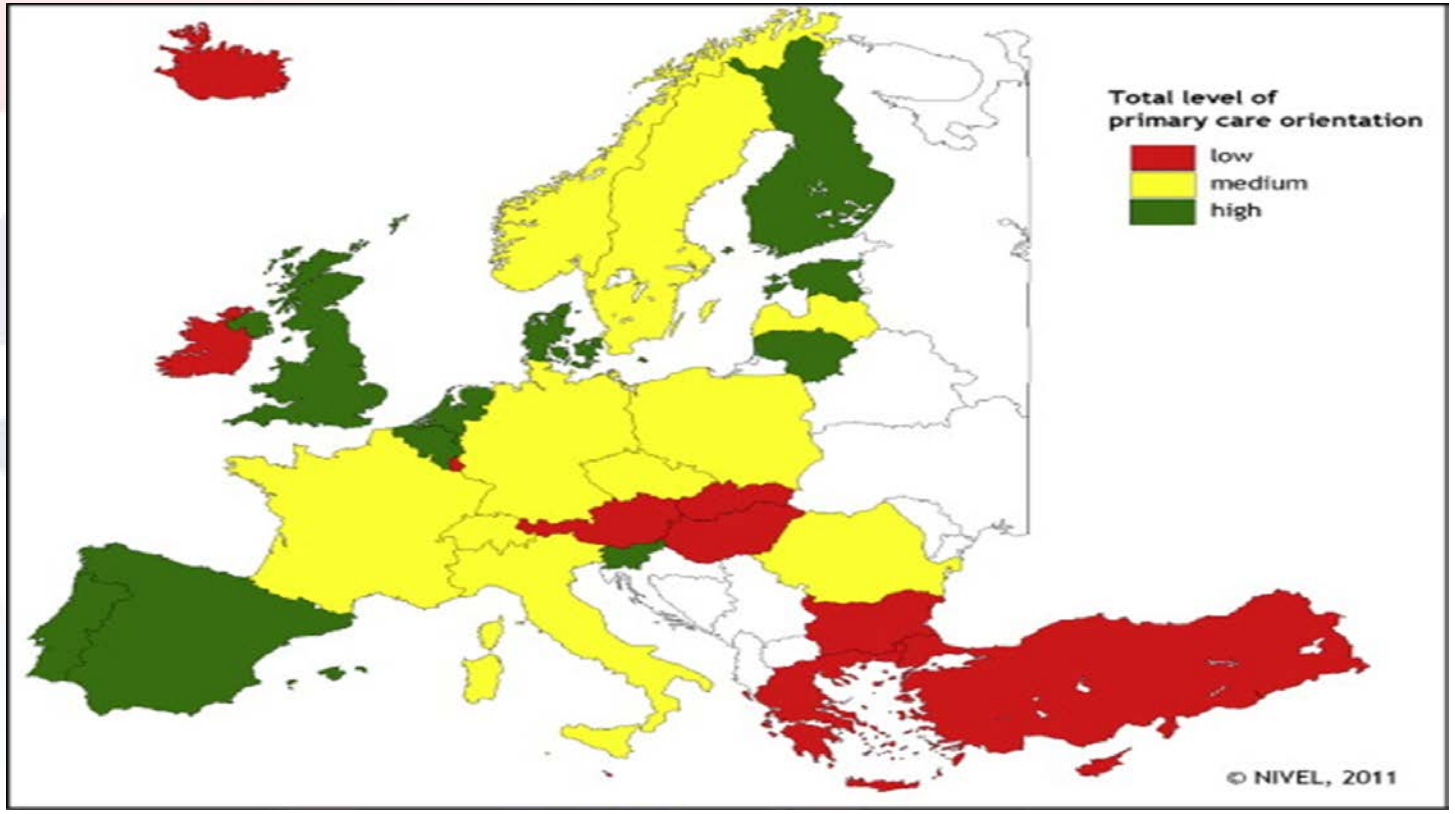


Driving factor 3: Communication

PCMH around the World

Survey of Five European Countries: That More Elements of Patient-Centered Medical Homes Improve Primary Care

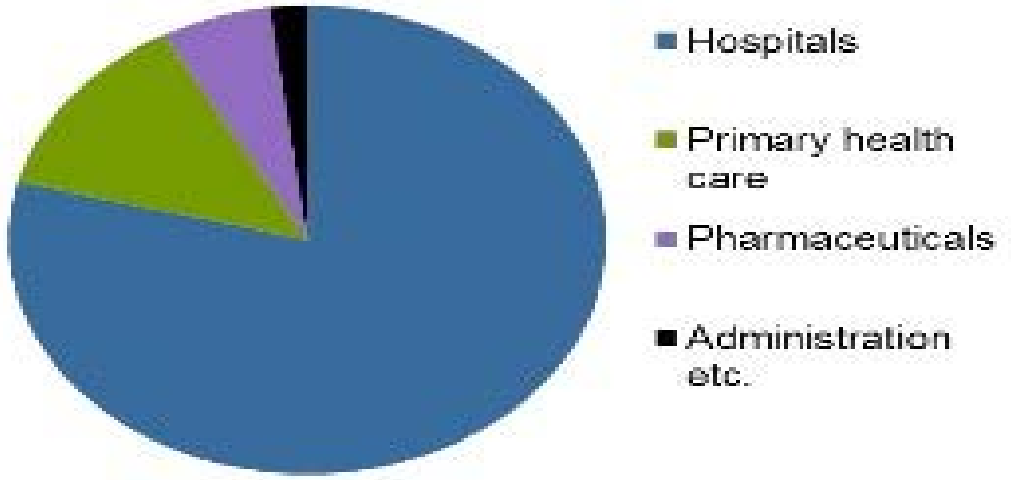
A large majority (87%–98%) of patients in Belgium, Denmark, Germany, and the Netherlands have a personal primary care physician and 78 percentage in England. However in the 209 PCH pilots in England it is 93%.



HEALTH AFFAIRSVOL. 32, NO. 4: THE 'TRIPLE AIM' GOES GLOBAL

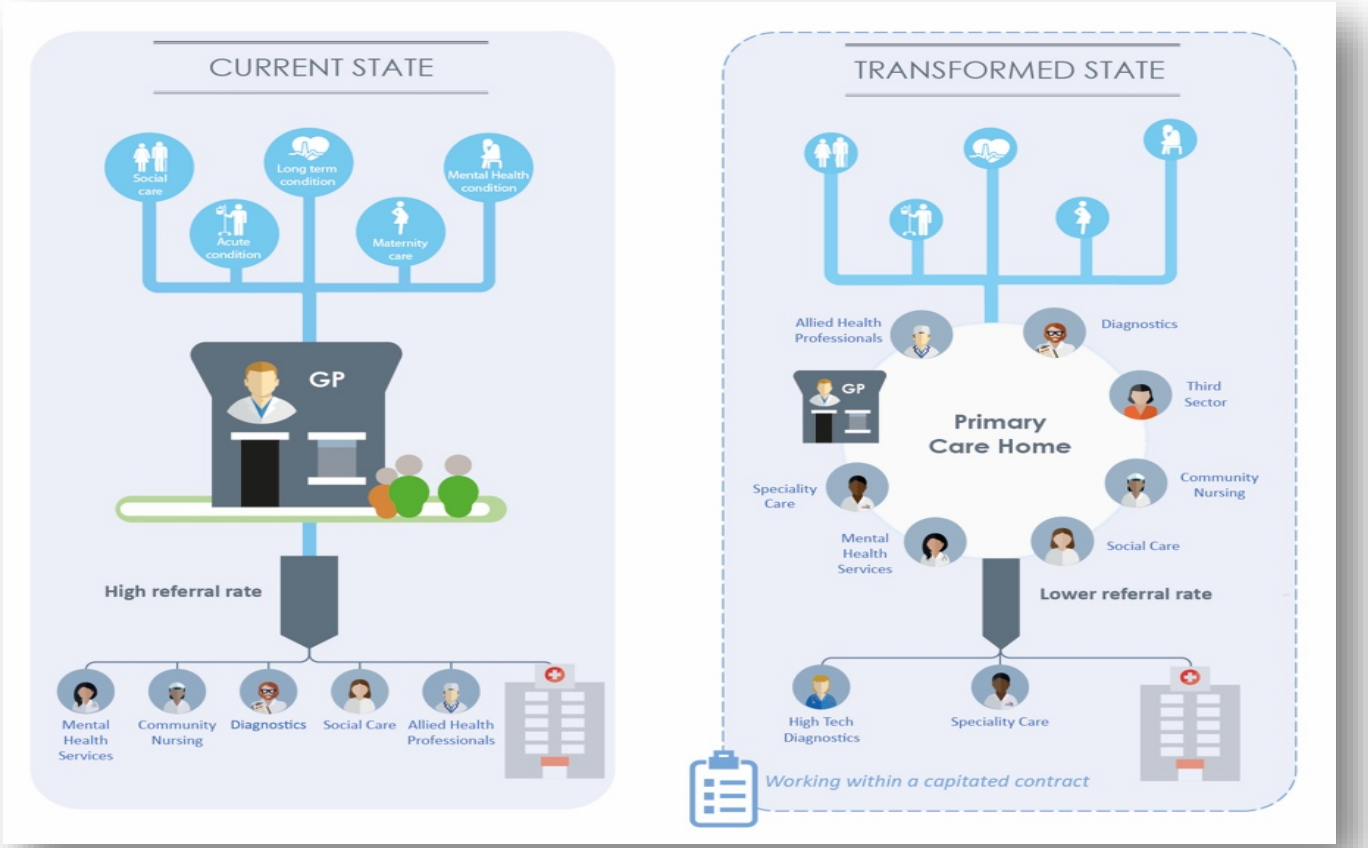
PUBLIC EXPENDITURE ON HEALTH REGIONS

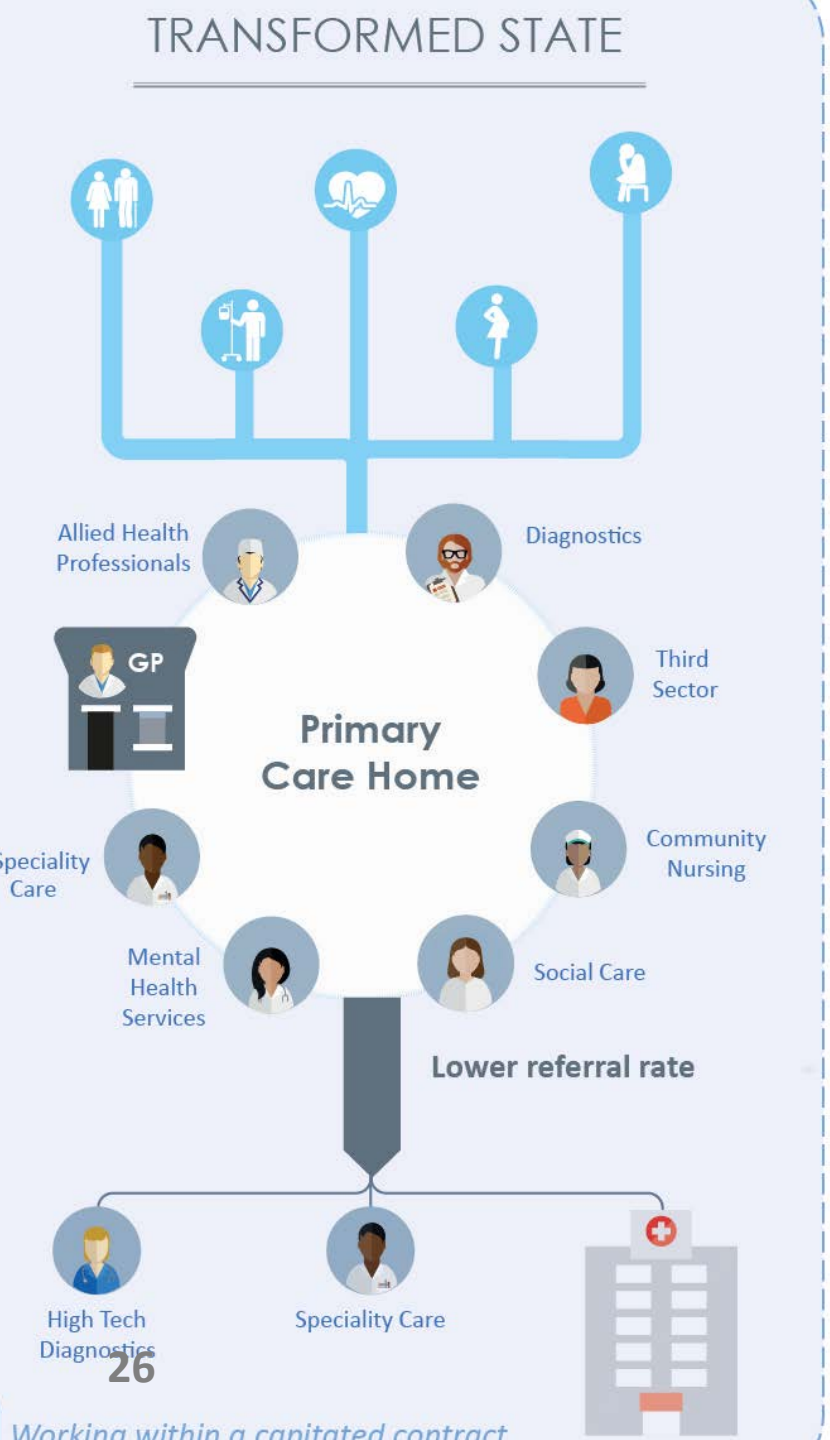
Hospitals	73%
Primary Healthcare	19%
Pharmaceuticals	6%
Administration	2%



Four core characteristics of a Primary Care Home

1. The provision of care to an evidence based, registered population size of 30,000 to 50,000 people
2. A combined focus on personalisation of care with improvements in population health planning, provision and outcomes
3. An integrated, multi-disciplinary workforce, with a strong focus on partnerships spanning primary, community, secondary, third sector, mental health and social care
4. Financial drivers aligned with the health needs of the whole population working towards managing a delegated whole population budget





The PCH model will deliver multiple benefits in Primary Care

- The 30-50k population of a PCH, through being the right size to scale and right size to care, brings benefits for the future development of Primary Care:

- **Improved patient care:** Enhancing proactive and person centred care by focusing on the needs of the person rather than the needs of the service. Enriching the experience of an individual in a care system with increased satisfaction, particularly in relation to good access to services
- **Increased staff fulfilment:** The PCH provides the environment and conditions for workforce development and effective team working, alleviating pressure across the local system and increasing the ability to attract and retain staff.
- **Improved utilisation of locals resources:** care teams that do the work take responsibility for a whole population budget for that registered community, redirecting resources from the acute sector where they can be more appropriately invested in primary care
- **Delivers improvements in General Practice:** multi-disciplinary teams in primary care will release more time for GPs
- **Helps to stabilise Primary Care:** make it easier for local providers to engage with each other and disparate units of Primary Care to coalesce into more robust units

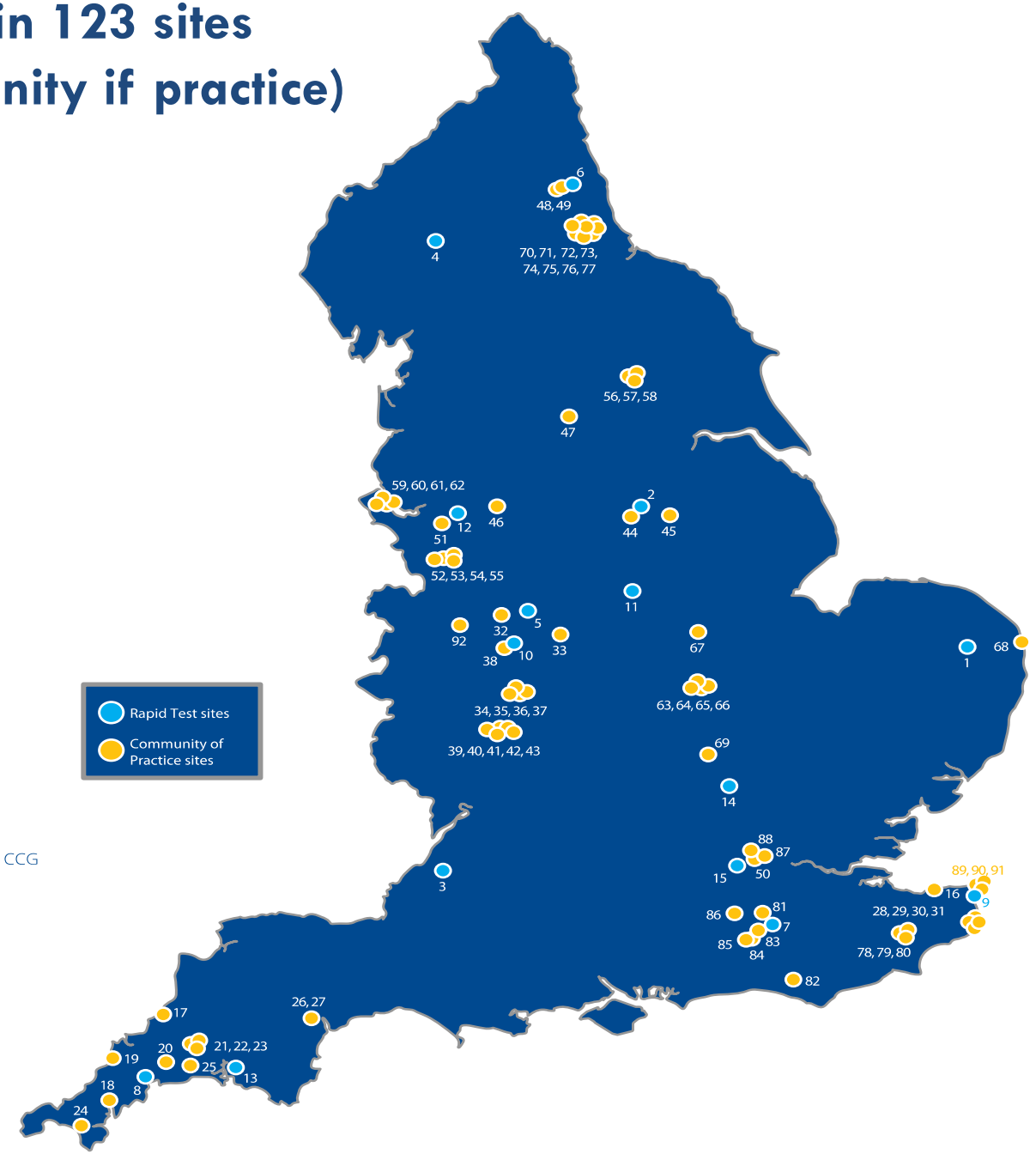
The PCH model is now active in 123 sites (with more joining the community if practice)

Rapid Test Sites

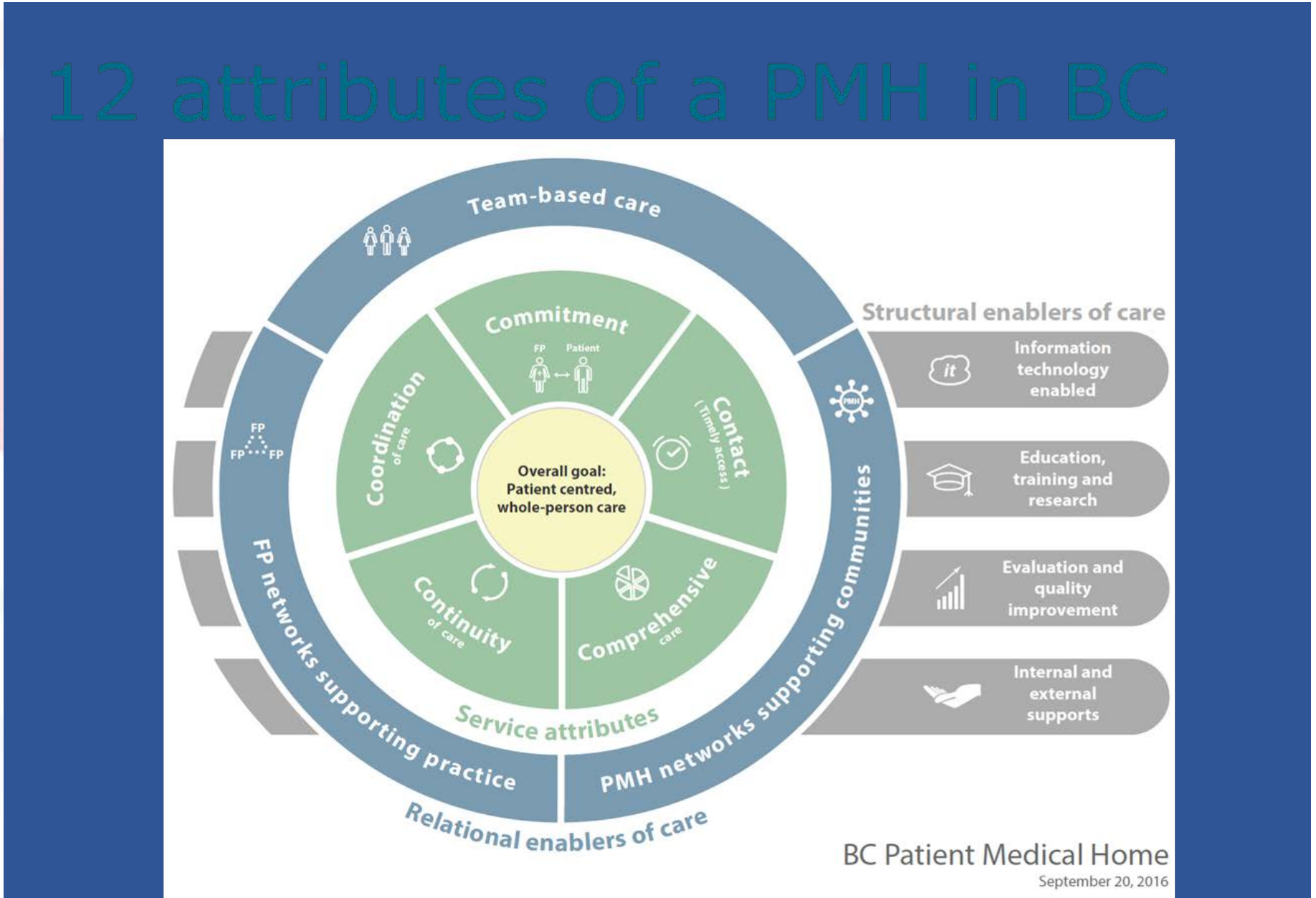
1. The Breckland Alliance
2. Larwood & Bawtry
3. South Bristol Primary Care Collaborative
4. 1st Care Cumbria
5. Rugeley Practices PCH
6. South Durham Health CIC
7. The Healthy East Grinstead Partnership
8. St. Austell Healthcare
9. Thanet Health CIC
10. Wolverhampton Total Health Care
11. Nottingham North & East Community Alliance
12. The Winsford Group
13. Beacon Medical Group
14. Luton Primary Care Cluster
15. Richmond

Community of Practice Sites

16 Herne Bay Health Care
17 North Cornwall MCP
18 Truro PCH
19 Perranporth & Penryn PCH
20 Lostwithiel, Fowey, St Blazey Primary care Network
21 22 23 East Cornwall Primary Care Home
24 South Kerrier Locality PCH
25 Penwith PCH
26 27 Integrated care Exeter
28 29 30 31 South Kent Coast Integrated Accountable Care
32 Stafford Primary Care Alliance
33 Lichfield / Burntwood Network
34 35 36 37 Redditch & Bromsgrave Alliance
38 Wolverhampton Care Collaborative
39 40 41 42 43 Wyre Forest Alliance
44 Newgate Medical Group
45 Riverside Health Centre
46 Middlewood Ltd
47 OneLeeds PCH
48 49 Derwentside Healthcare LTD
50 Hammersmith & Fulham GP Federation (Network3)
51 Central Crewe Cluster
52 53 54 55 South Cheshire and Vale Royal Primary Care Home Network
56 57 58 Nimbus Care York
59 60 61 62 Wirral GP Provider Federation
63 64 65 66 3Sixty Care
67 Rutland Medical Group
68 East Norfolk Medical Practice
69 Newport Pagnell Medical Centre
70 71 72 73 74 75 76 77 Durham Dales, Easington and Sedgefield CCG
78 79 80 Ashford Clinical Providers Network Ltd (Federation)
81 Redhill & Merstham
82 Lewes Health Hub
83 Horsham PCH
84 Burgess Hill and Villages PCH
85 Haywards Heath PCH
86 Dorking Primary Care Home
87 South Camden Primary Care Neighbourhood
88 Hampstead Primary Care Neighbourhood
89 90 91 Ramsgate PCH, Margate PCH, Quex PCH, Broadstairs PCH
92 Newport District Neighbourhood project



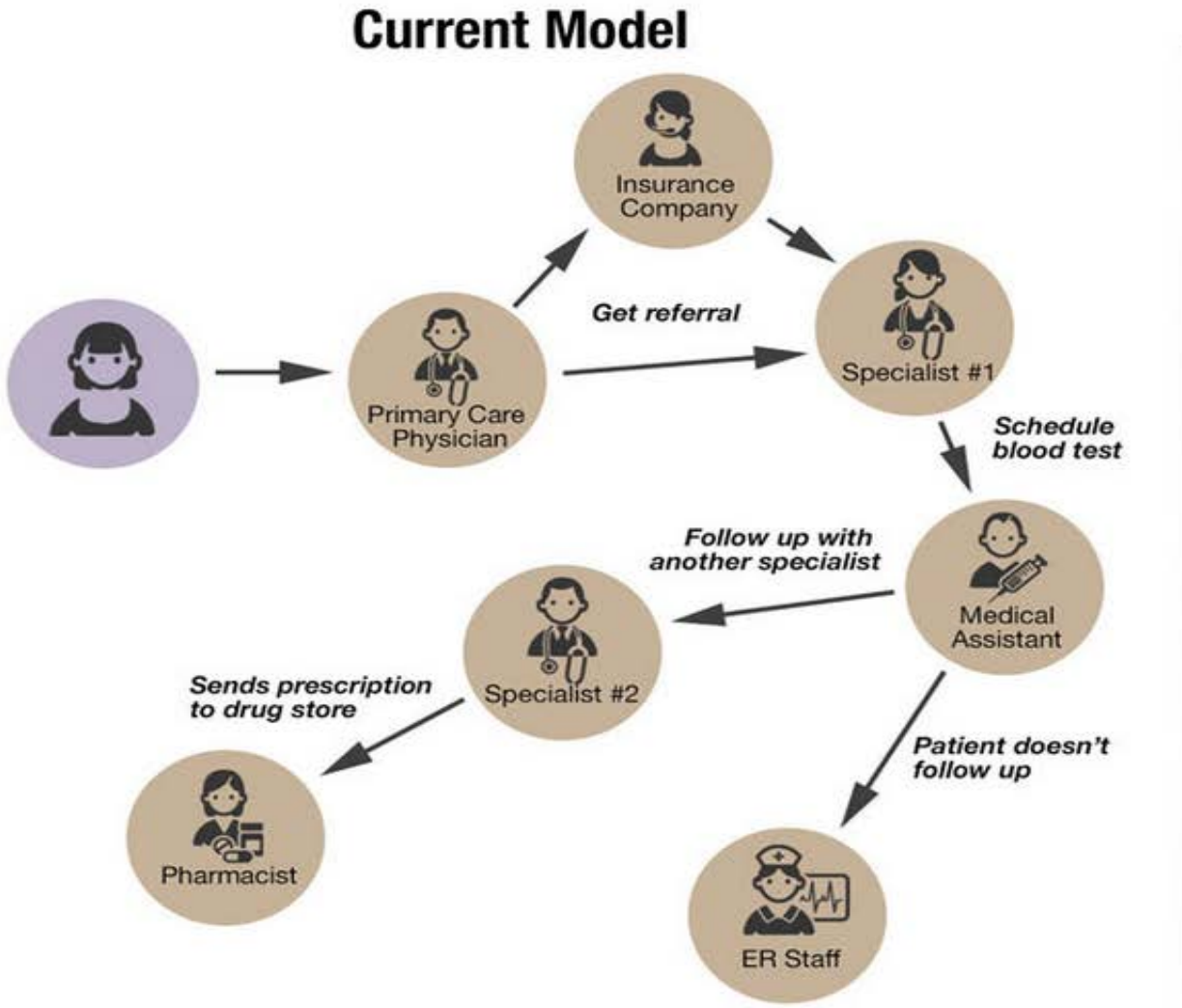
12 Attributes of PCH in British Columbia

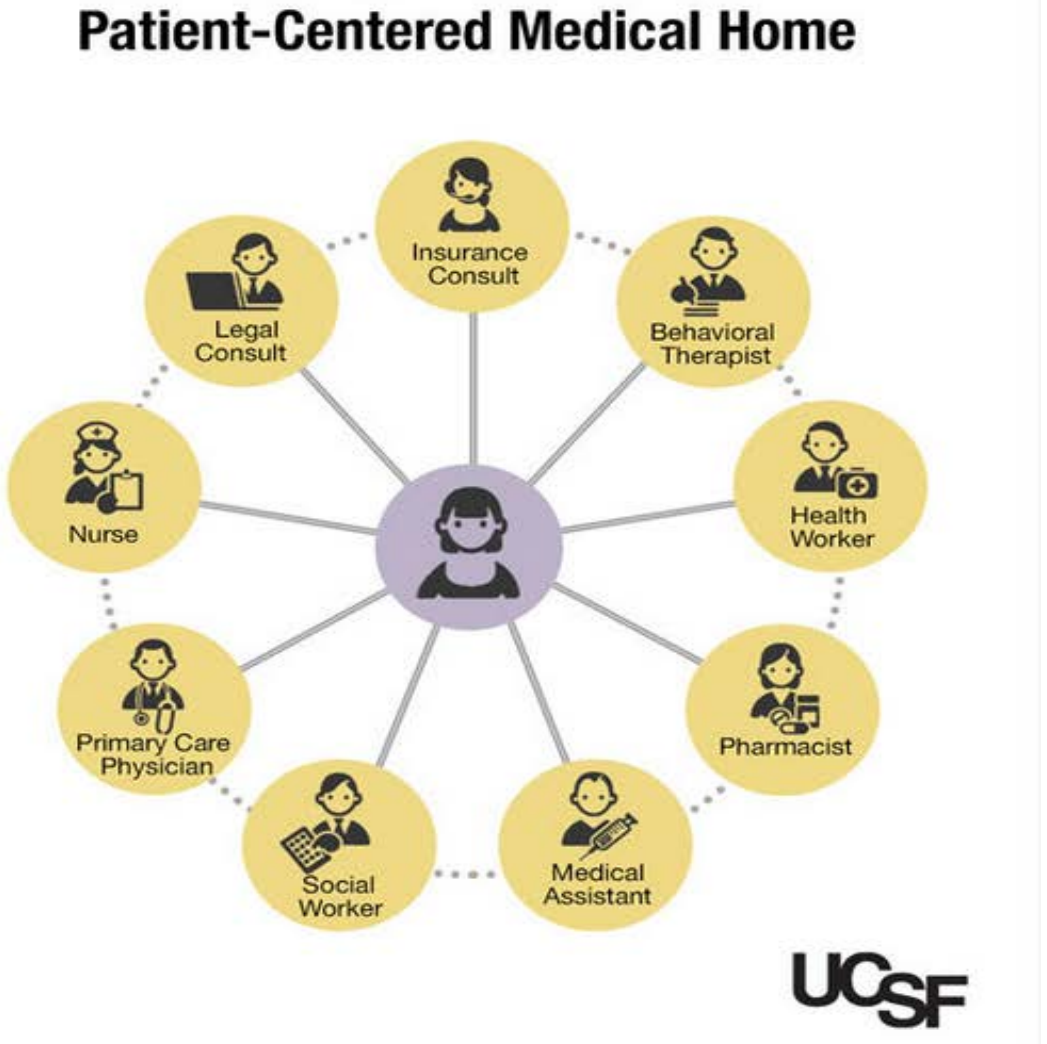


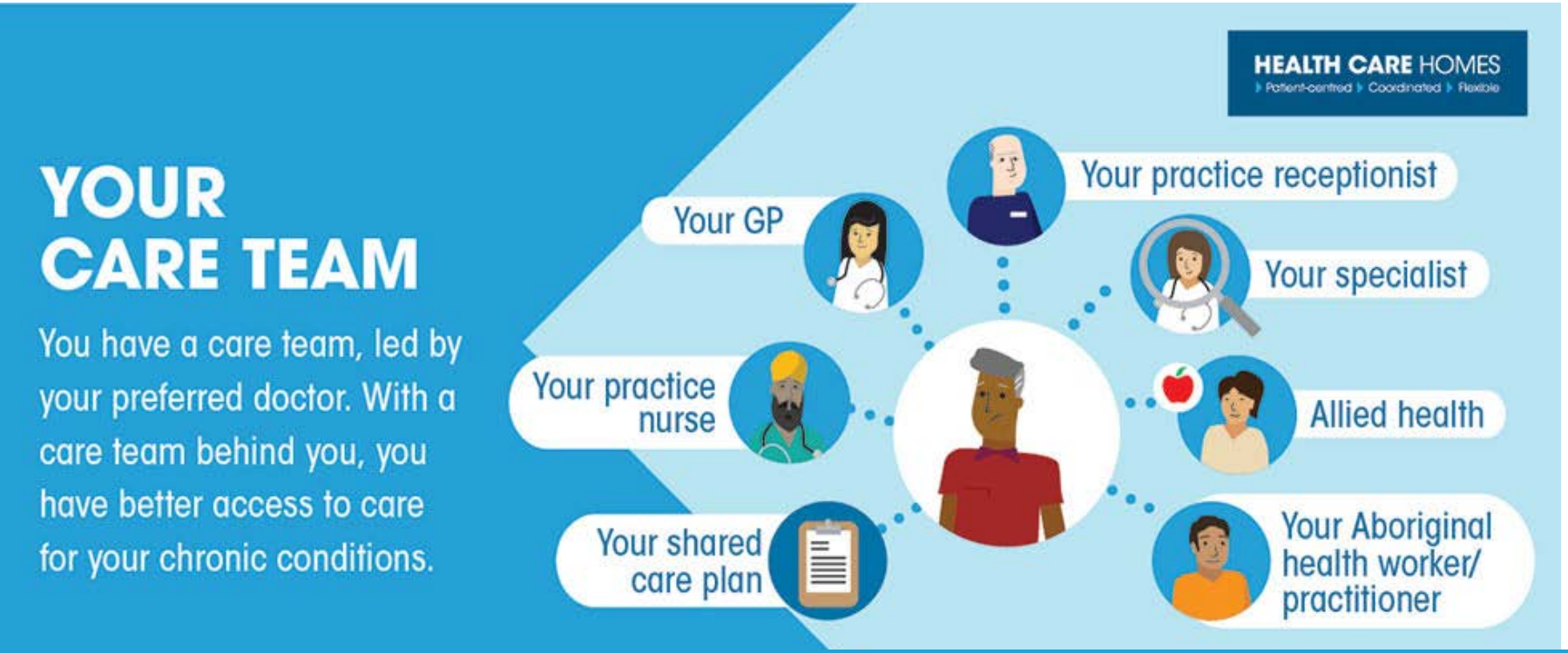
- From Dr Brenda Hefford Executive Director,
- Community Practice,
- Quality and Integration

Australia Rethinking Primary Care

Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:







To better serve Australians the government has announced plans to expand the Health Care Homes model to up to 65,000 Australians. The model, currently in trial at 22 clinics, will be offered at an additional **168 general practices** and Aboriginal Community Controlled Health Services clinics within the coming year.

The Health Care Homes model provides integrated, team-based care focused on patients' goals and needs. Given that practices receive per capita fees, the model provides incentives to focus on the most complex and highest-cost patients.

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes

http://www.health.gov.au/internet/main/publishing.nsf/650f3eec0dfb990fca25692100069854/1d9a22e753dfa9bdca257fb100033a6a/WebPageBody/0.B3E?OpenElement&FieldElemFormat=jpg

Defining the Medical Home

The medical home is an *approach* to primary care that is:

Person-Centered
Supports patients and families in managing decisions and care plans

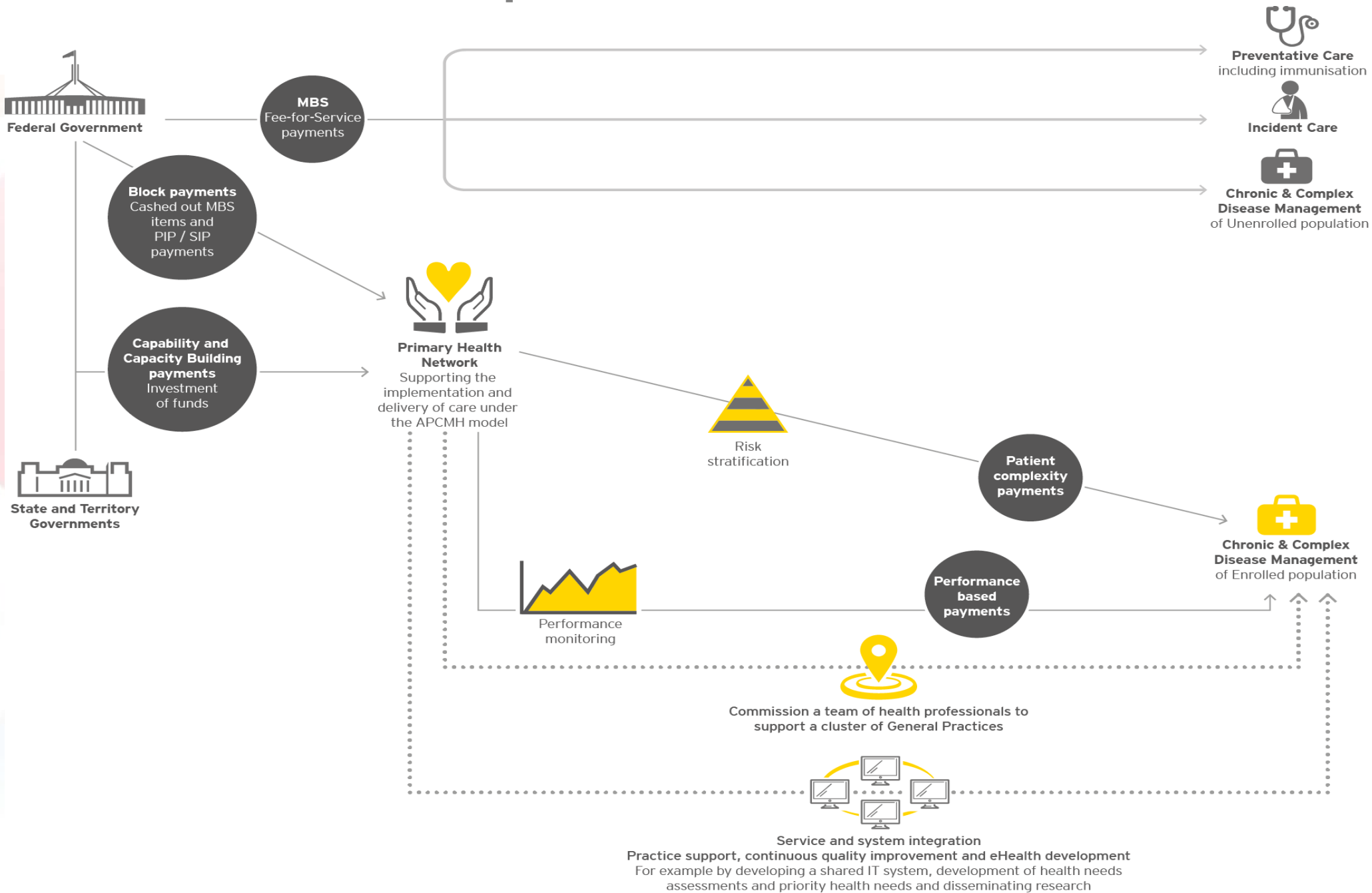
Comprehensive
Whole-person care provided by a team

Coordinated
Care is organized across the 'medical neighborhood'

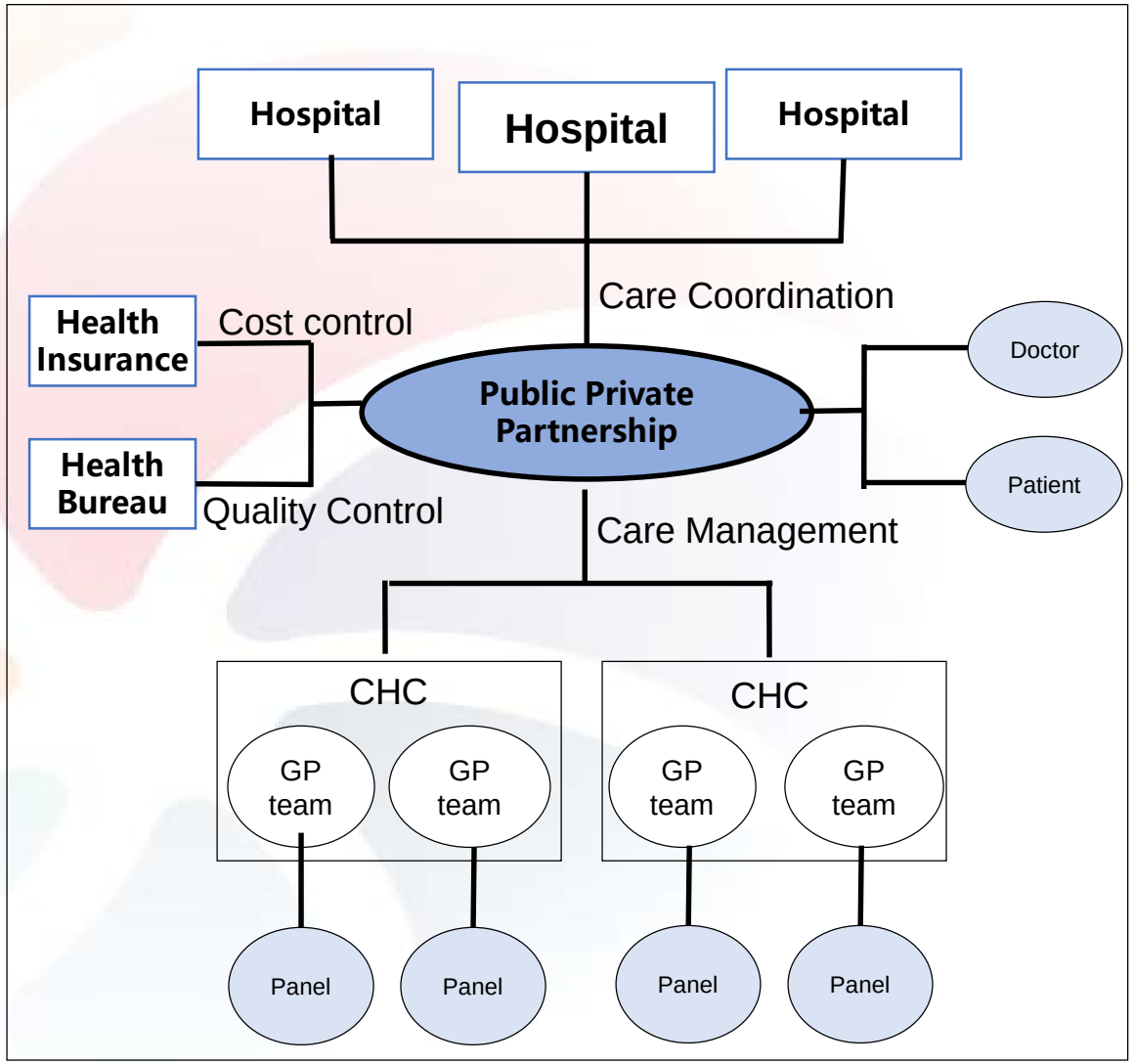
Committed to Quality and Safety
Maximizes use of health IT, decision support and other tools

Accessible
Care is delivered with short waiting times, 24/7 access and extended in-person hours

How the model could operate in the Australian health care system



Wuhou China PCMH Pilot



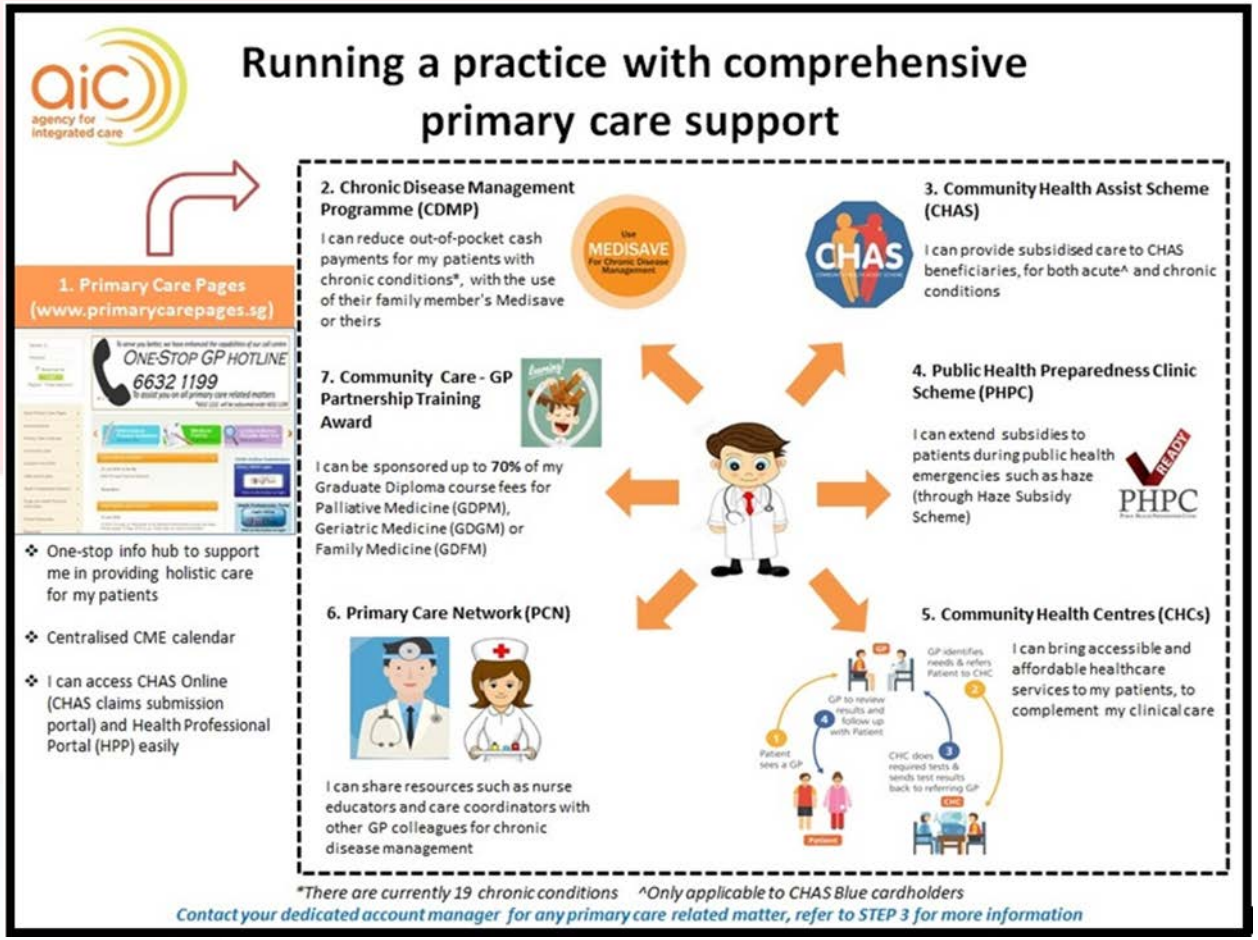
Care Coordination

- 专家预约
- 双向转诊
- 代理检验
- 代理检查
- 远程阅片
- 远程会诊

Care Management

- 患者签约
- 健康档案
- 健康评估
- 健康计划
- 团队协作
- 监测评估
- 医患互动
- 过程优化

Singapore

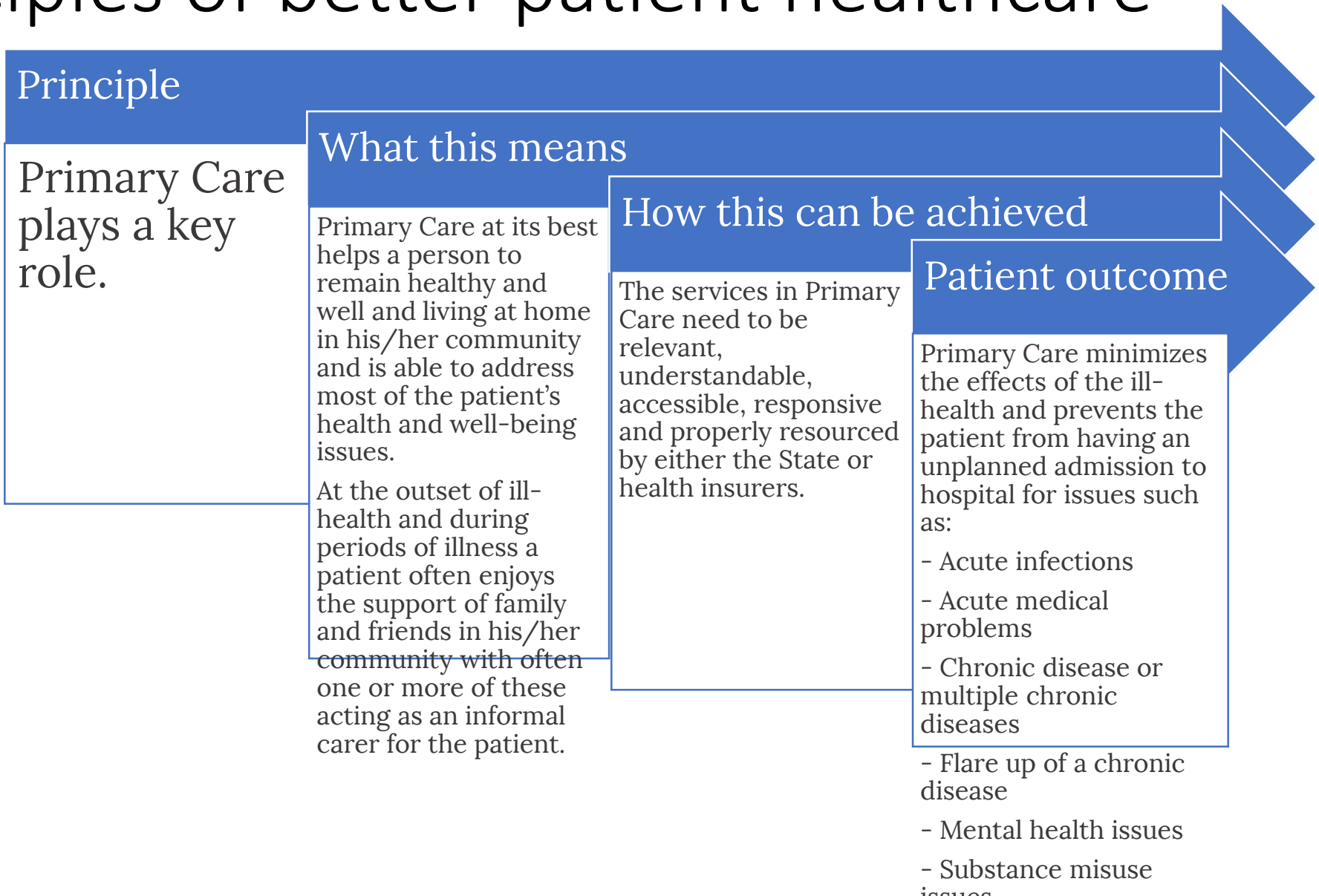


https://www.nuh.com.sg/umc/patients-and-visitors/support-groups-and-programmes/patient-centered-medical-home.html

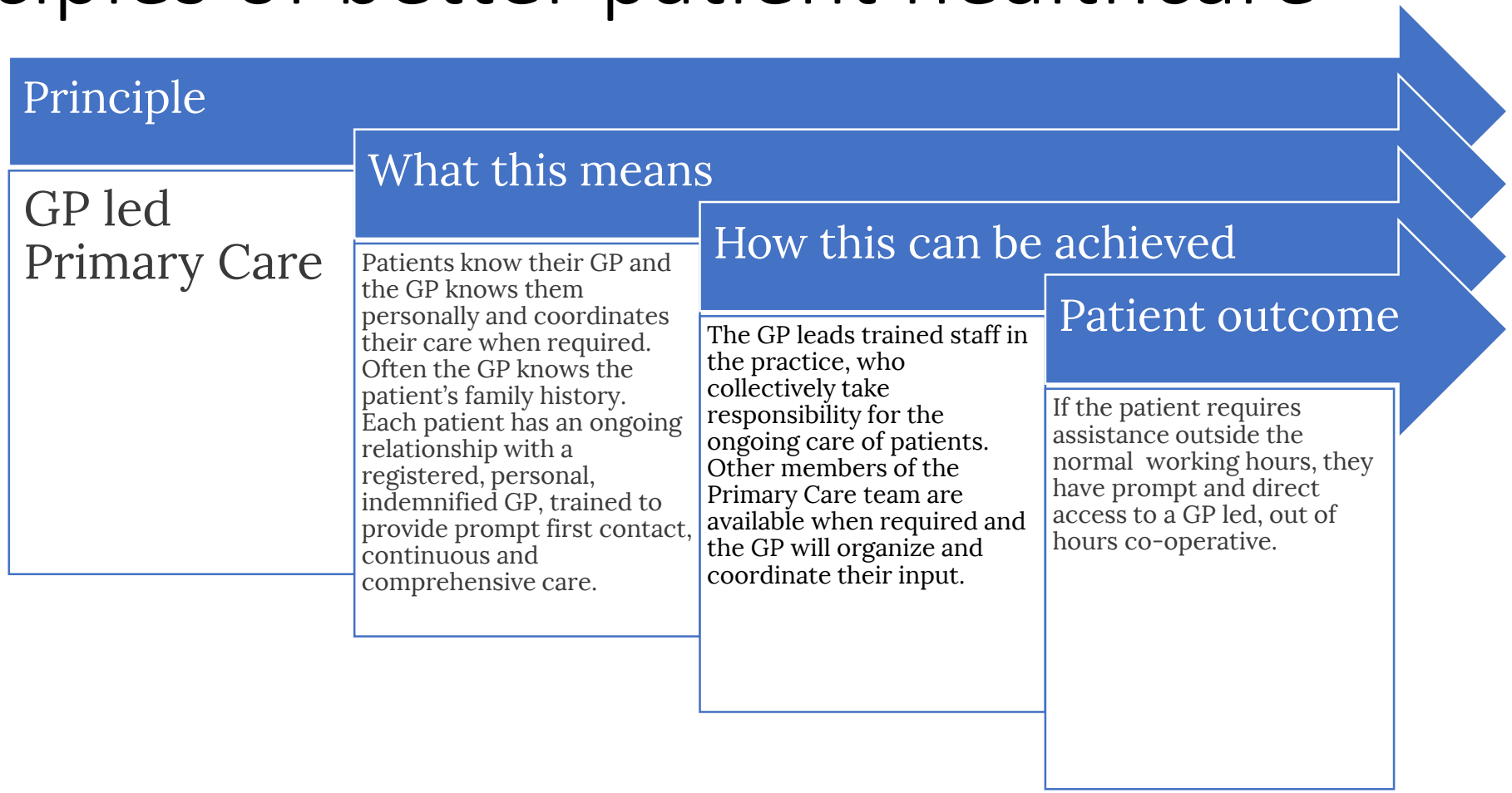
Ireland Principles of better patient healthcare

- Primary Care plays a key role
- Healer relationship of trust led Primary Care
- Comprehensive care
- Co-ordinated care
- Accessible care

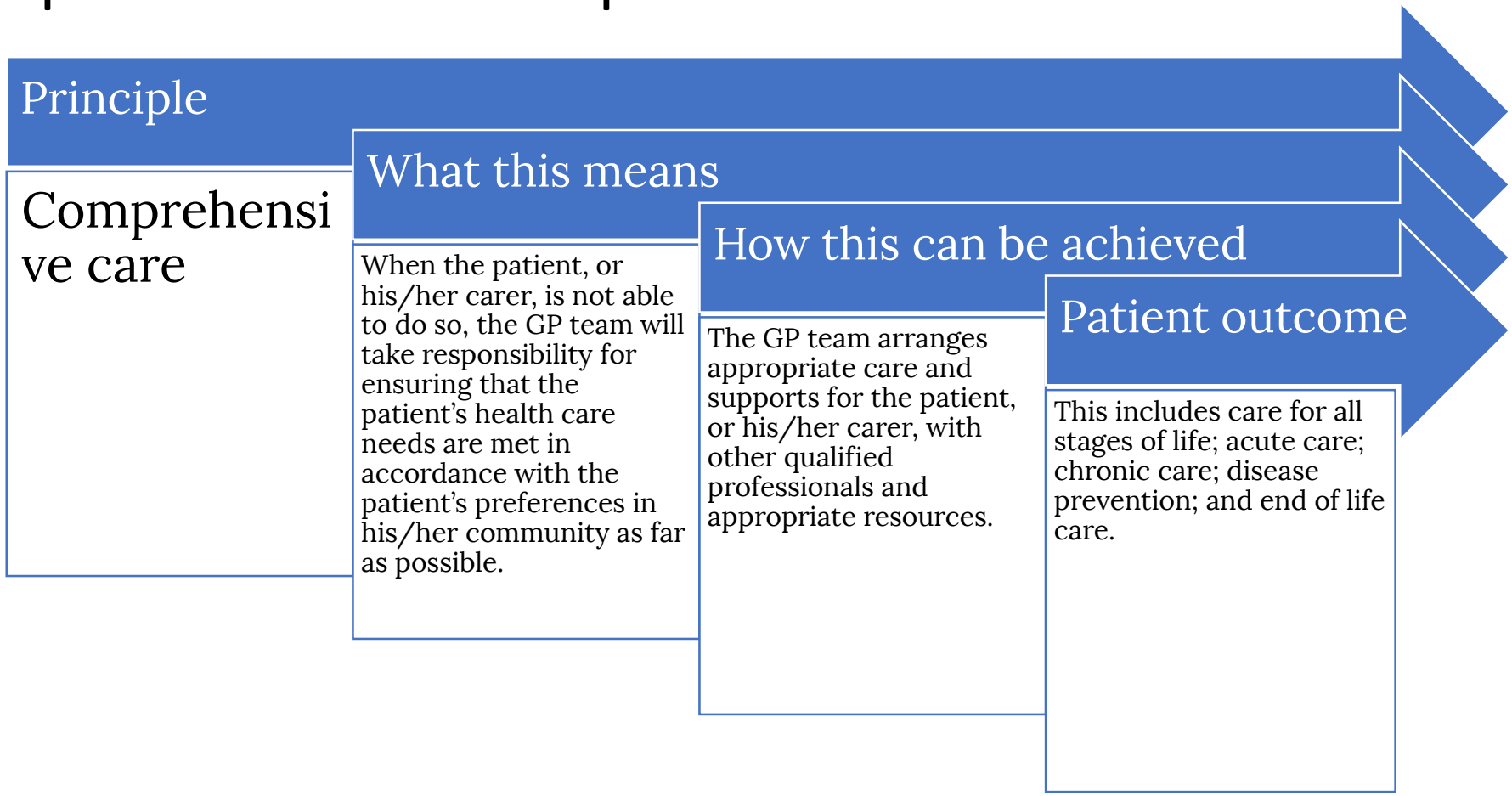
Principles of better patient healthcare



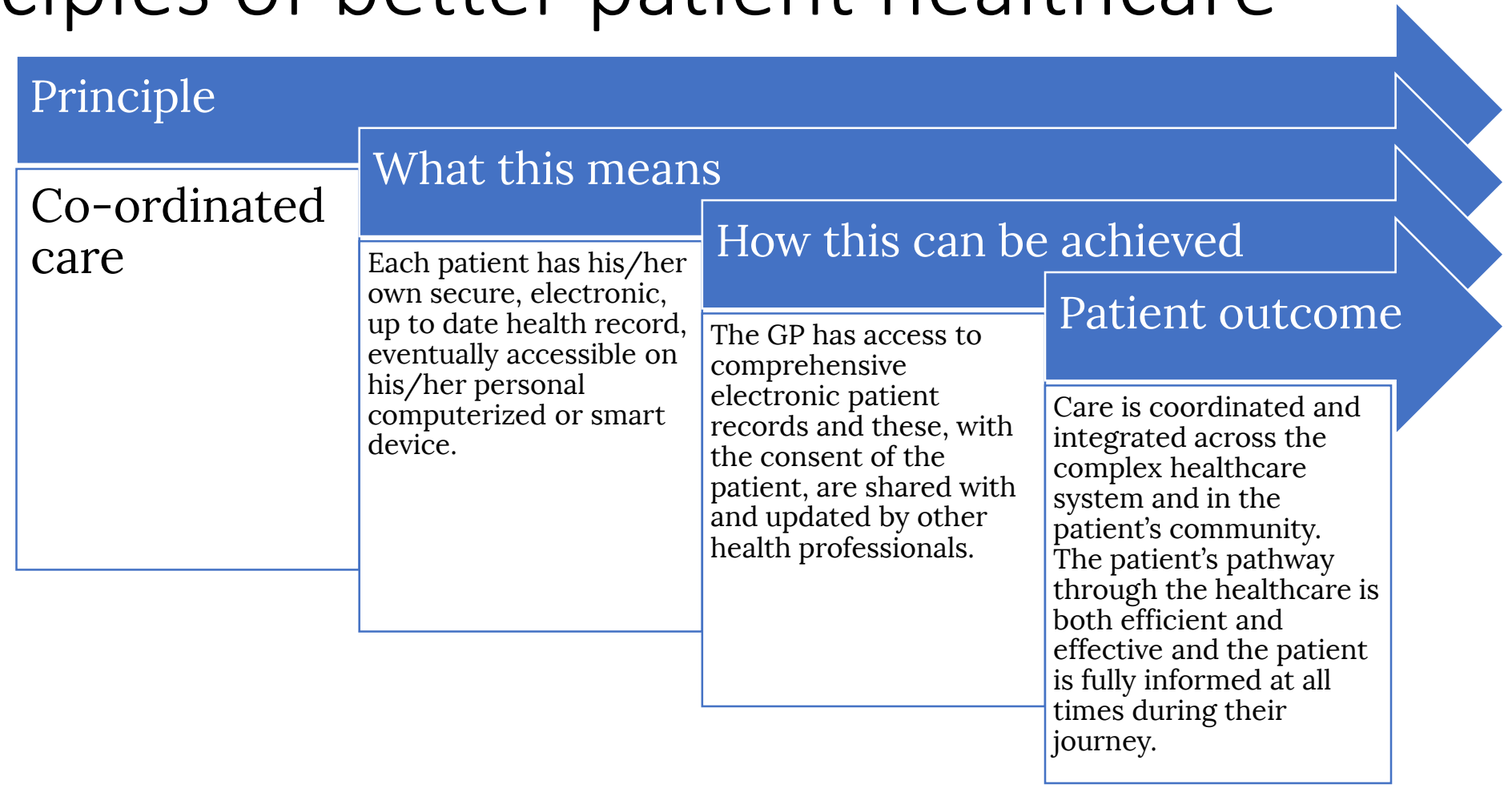
Principles of better patient healthcare



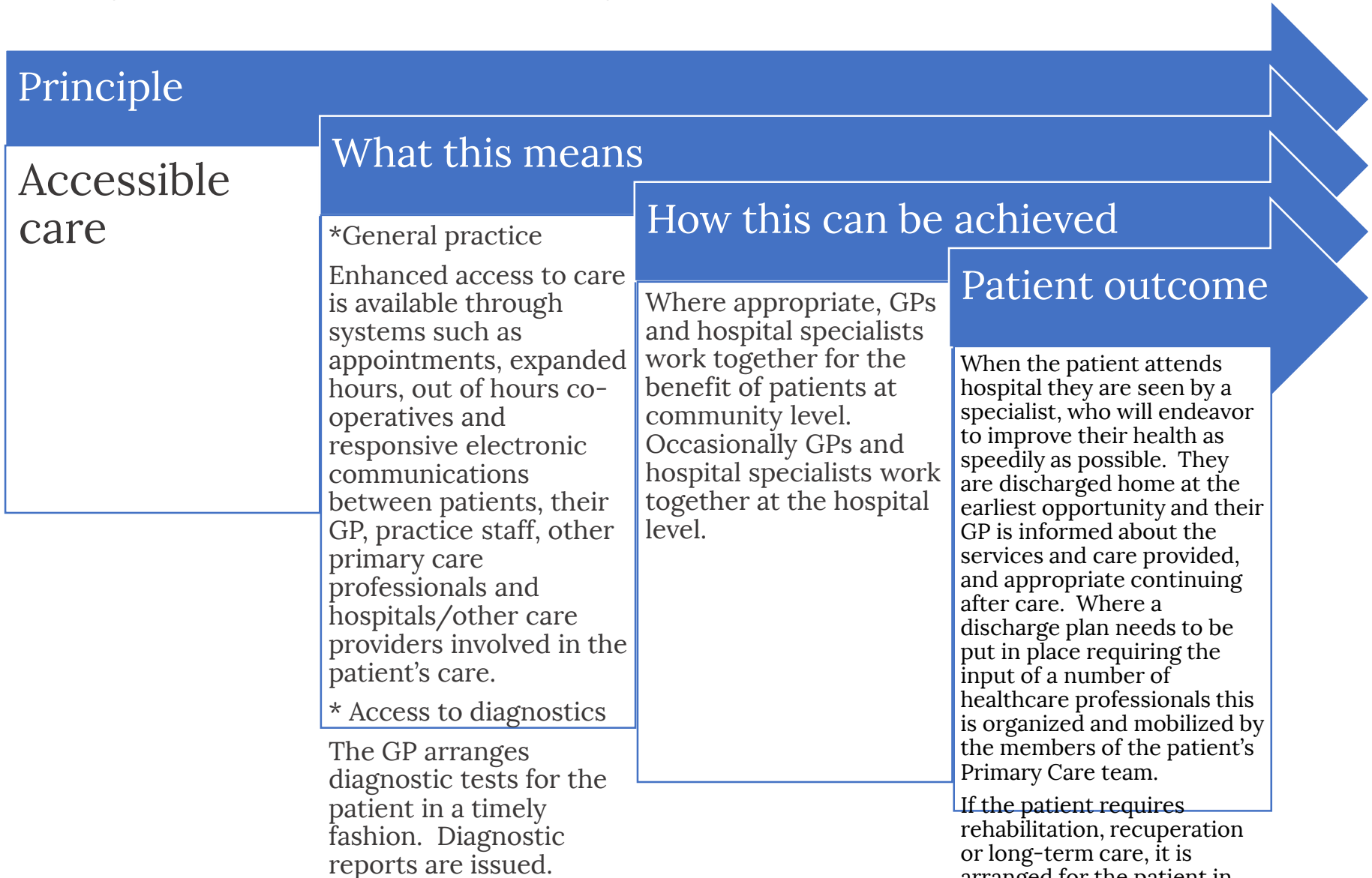
Principles of better patient healthcare



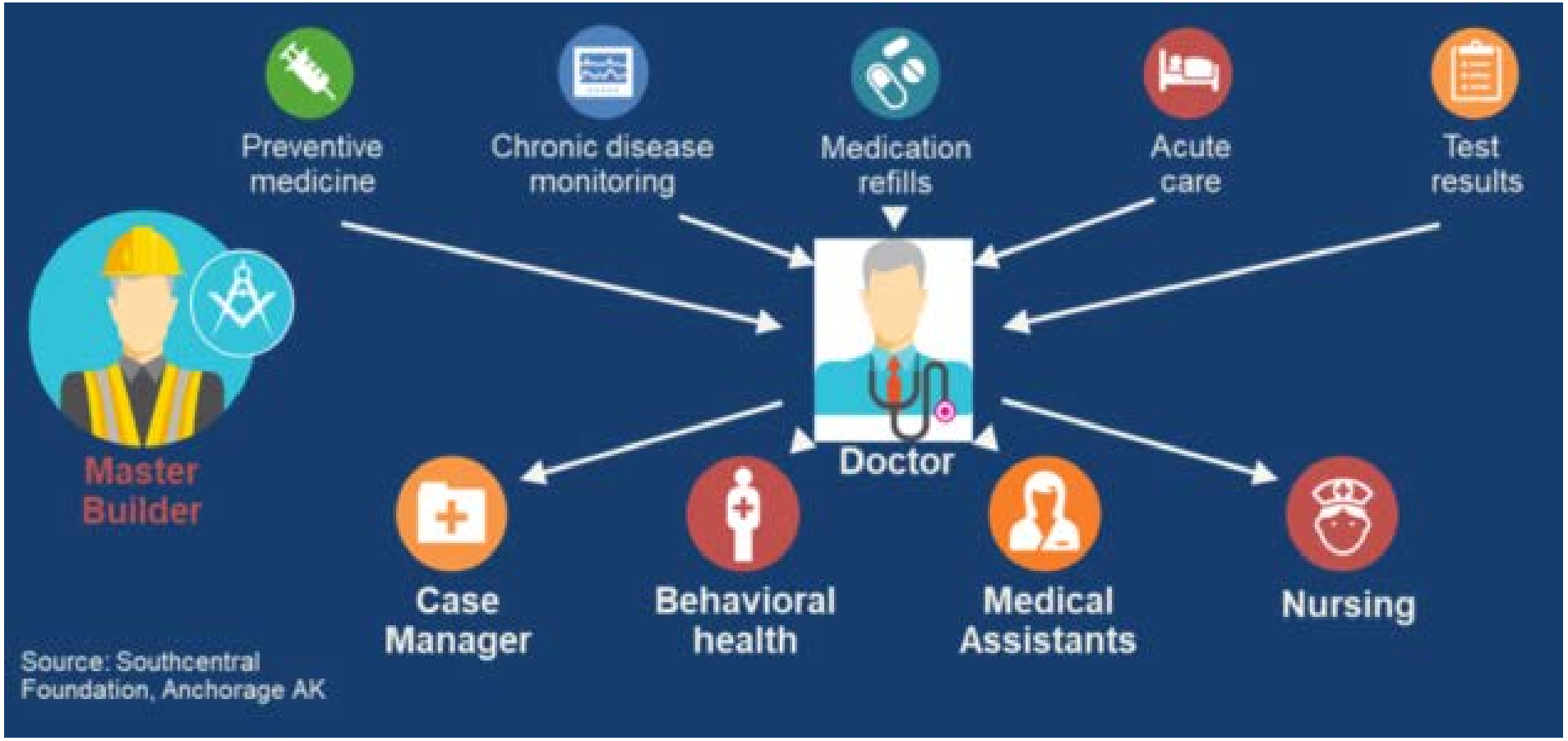
Principles of better patient healthcare



Principles of better patient healthcare



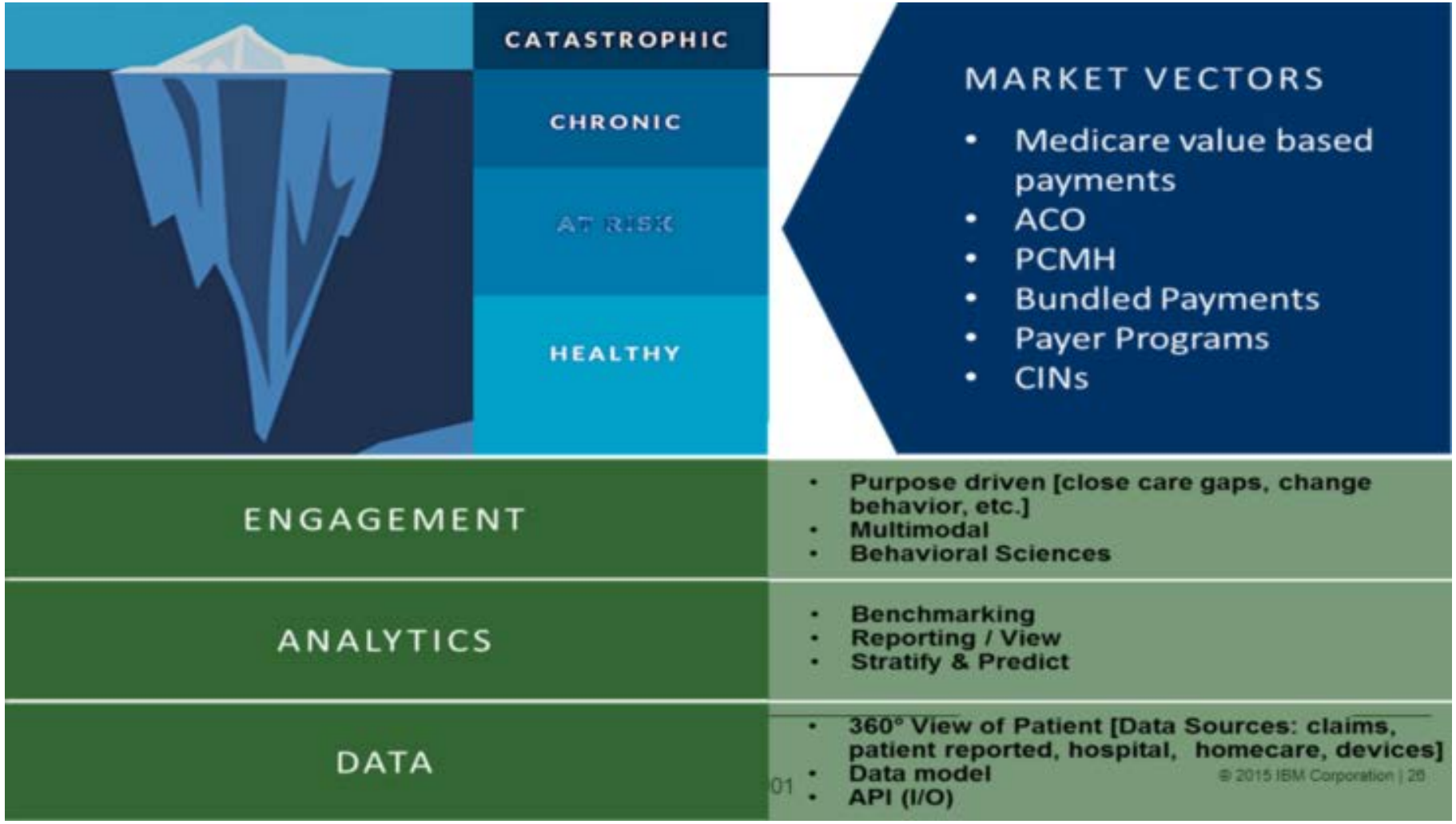
Practice transformation away from episode of care



New model of care – putting the patient first

Future healthcare transformation

Patients, Payments, Tools & Value



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 & time available today	Care is determined by a proactive plan to meet patient needs with or without visits
Care varies by scheduled time & 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 & 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 content from Daniel Duffy, MD, School of Community Medicine Tulsa Oklahoma

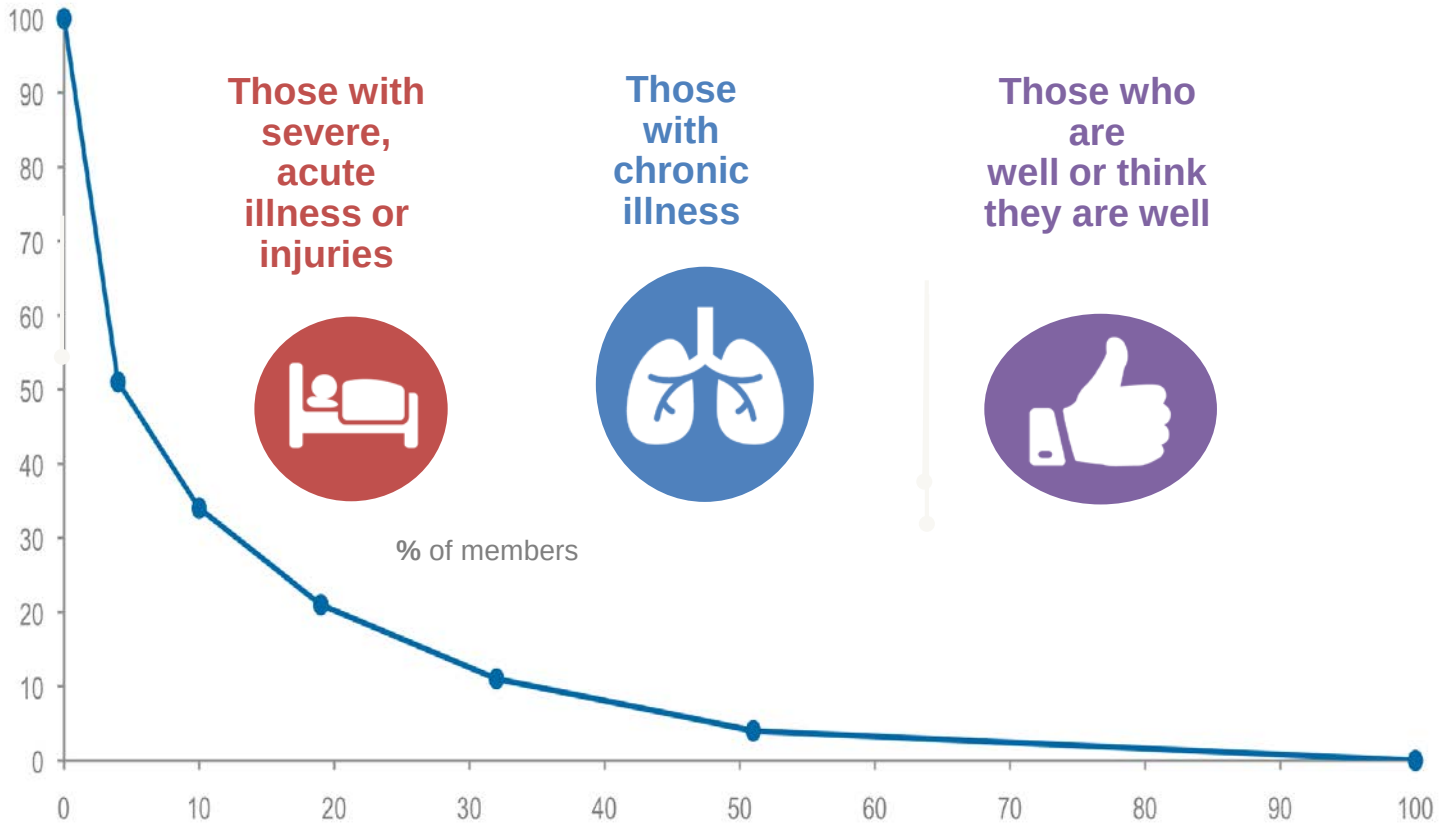
Defining the care centered on the patient

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

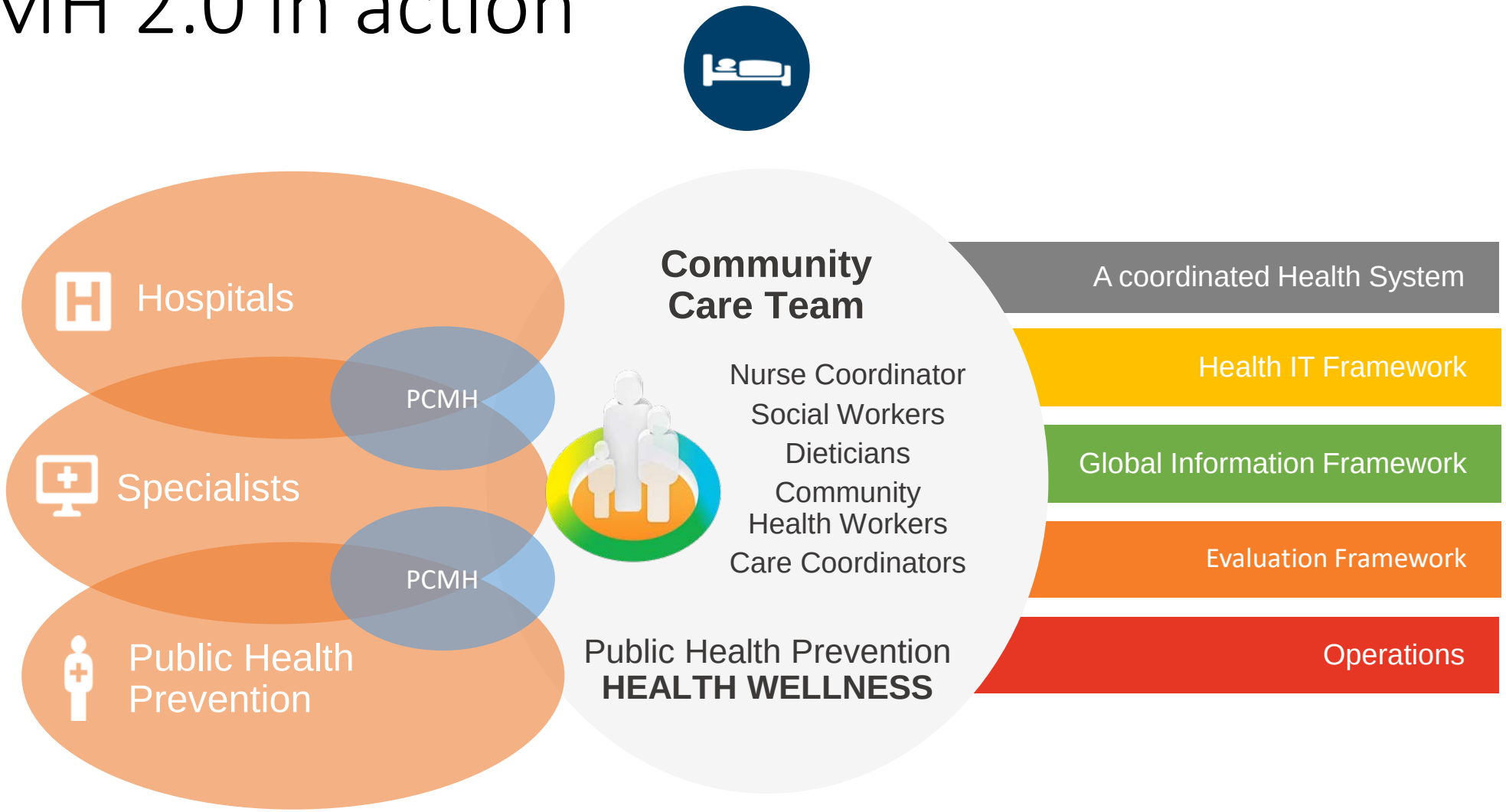
- Team care
- Communication/ Patient feedback
- Mobile – easy to use & available information

Benefit redesign – patient engagement

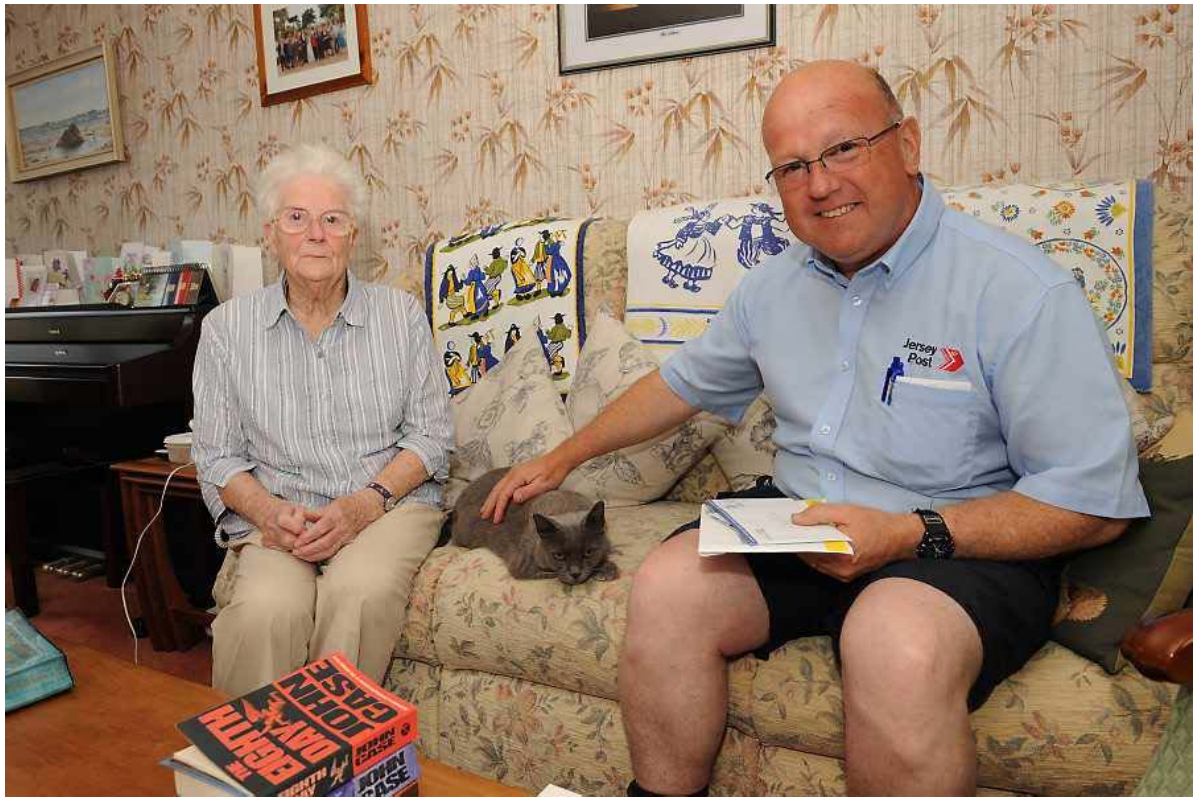
Different strategies for different Healthcare



PCMH 2.0 in action



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



Thank You

Questions?

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