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The Intersection of Public Health and Primary Care

Bruce Bagley, MD
Interim President and CEO

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Today's Conversation

- Brief Environmental Scan
- Patient Centered Medical Home
- The Medical Neighborhood
- Accountable Care Organizations
- Community Involvement
- Public Health

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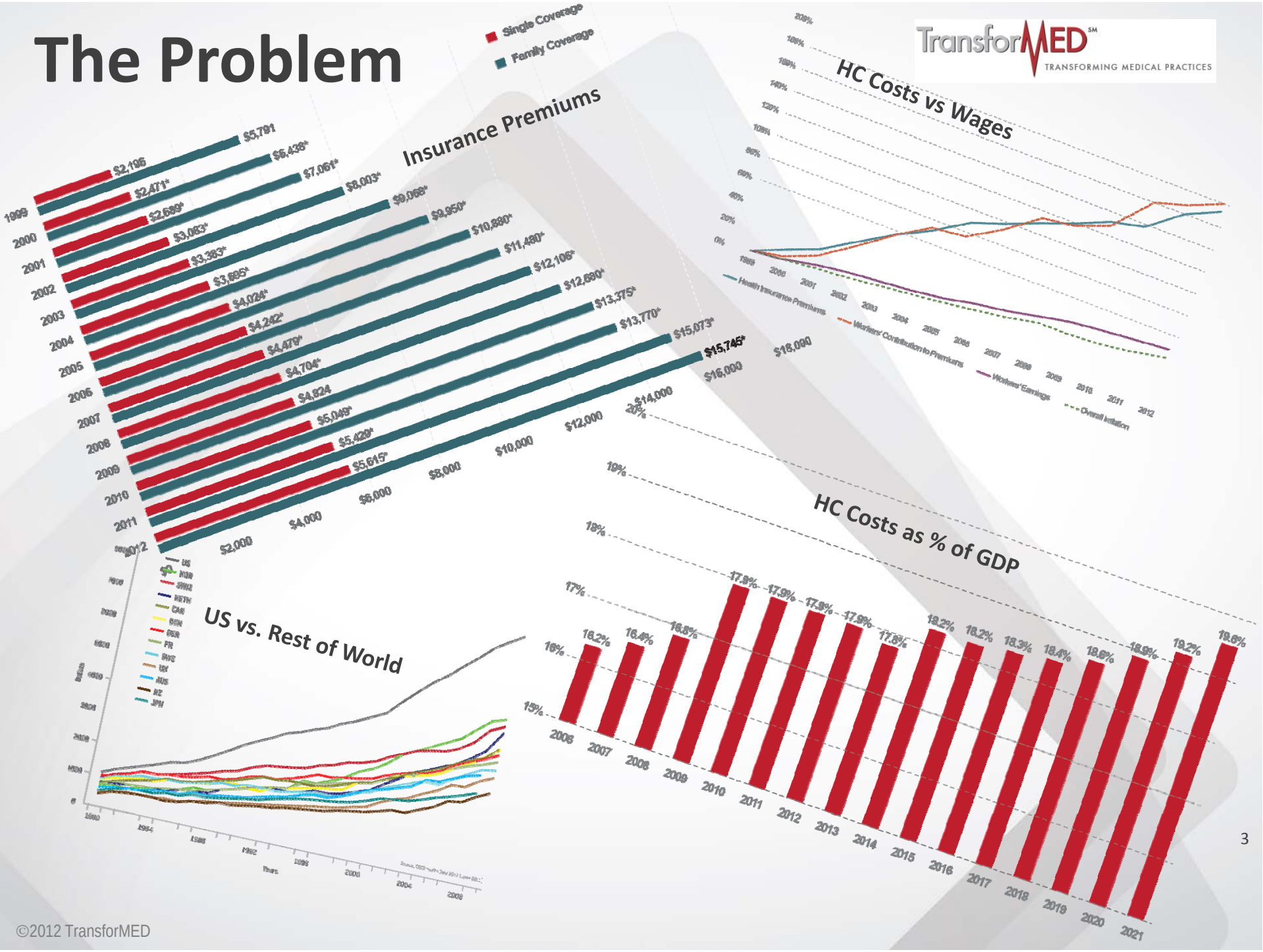
The Problem



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10 Drivers of Unsustainable Healthcare Costs

1. Fee-for-service reimbursement
2. Fragmentation of care delivery
3. Administrative burden
4. Population aging
5. Chronic diseases and lifestyle choices
6. Medical technology
7. Lack of transparency of cost and quality information
8. Market competition and consolidation
9. Medical malpractice, fraud and abuse
10. Trends in specialization and patient access to providers

PayerFusion.com -CEO Blog 11/19/2012

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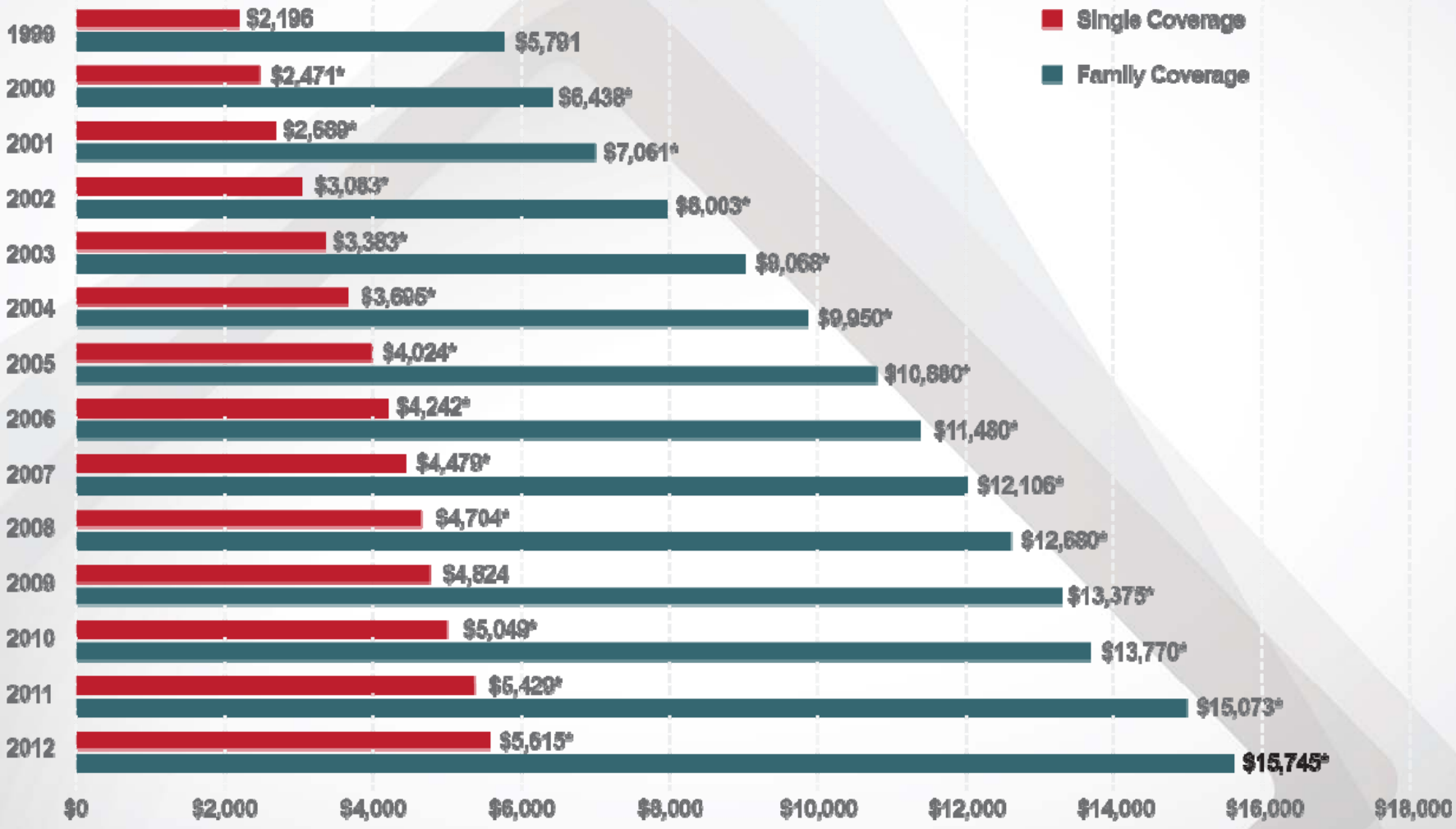
Average annual premiums for single and family coverage, 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012.

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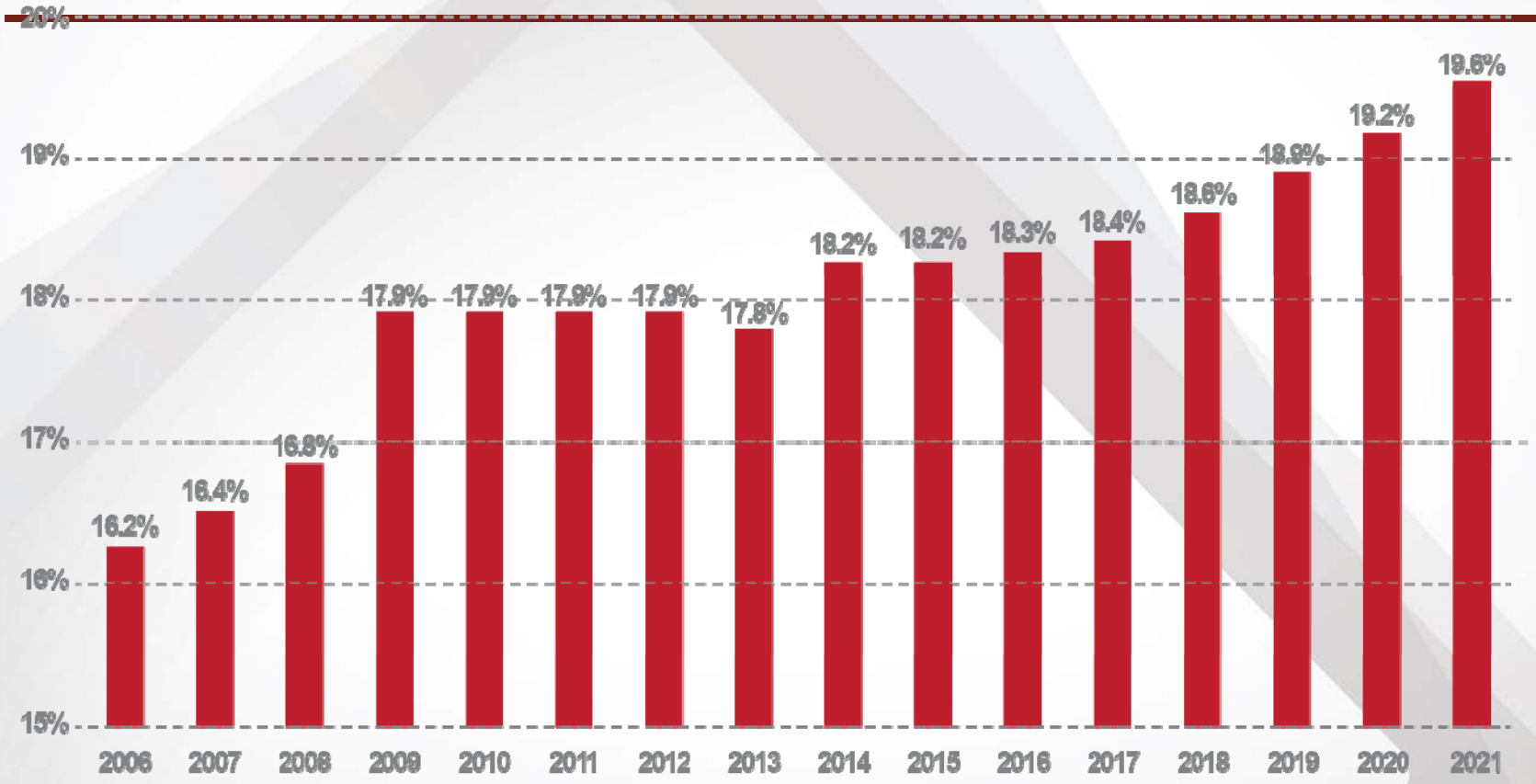
Health expenditures as a percentage of GDP



**2012-2021 Are Projections*
Source: CMS National Health Expenditures Projections 2011-2021

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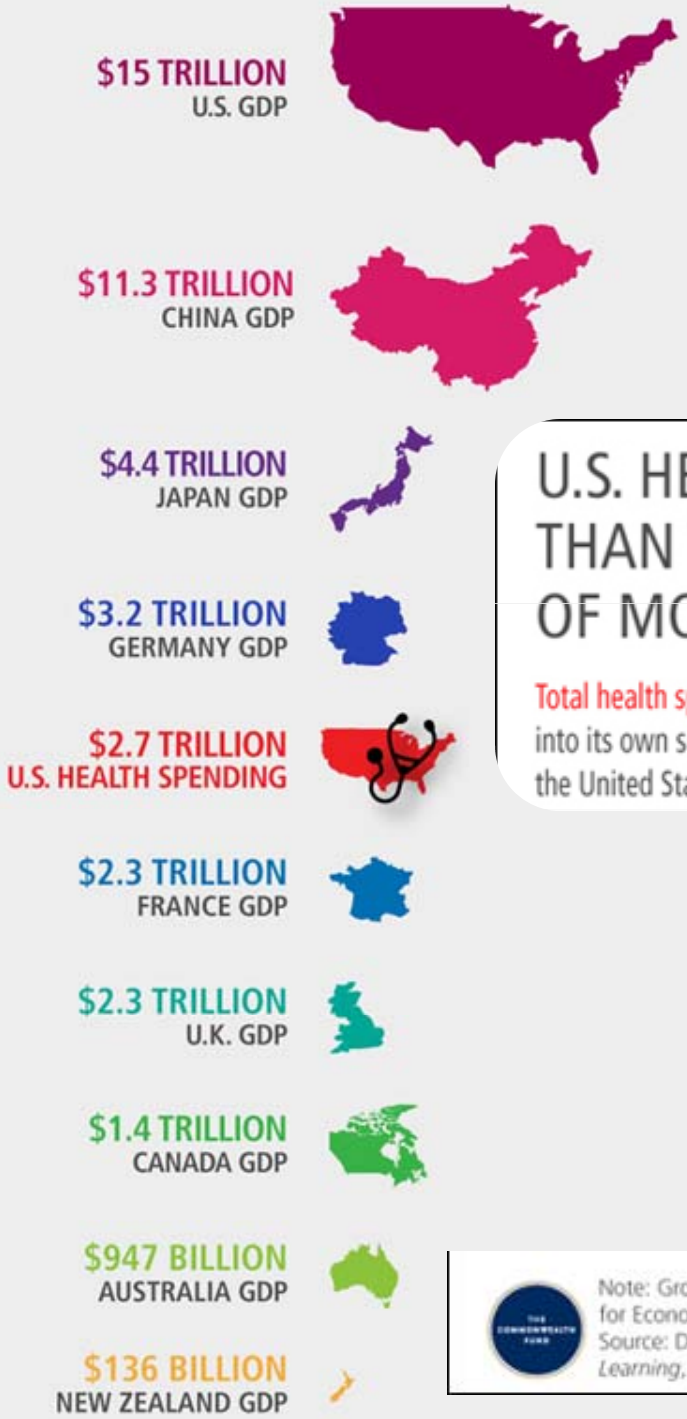
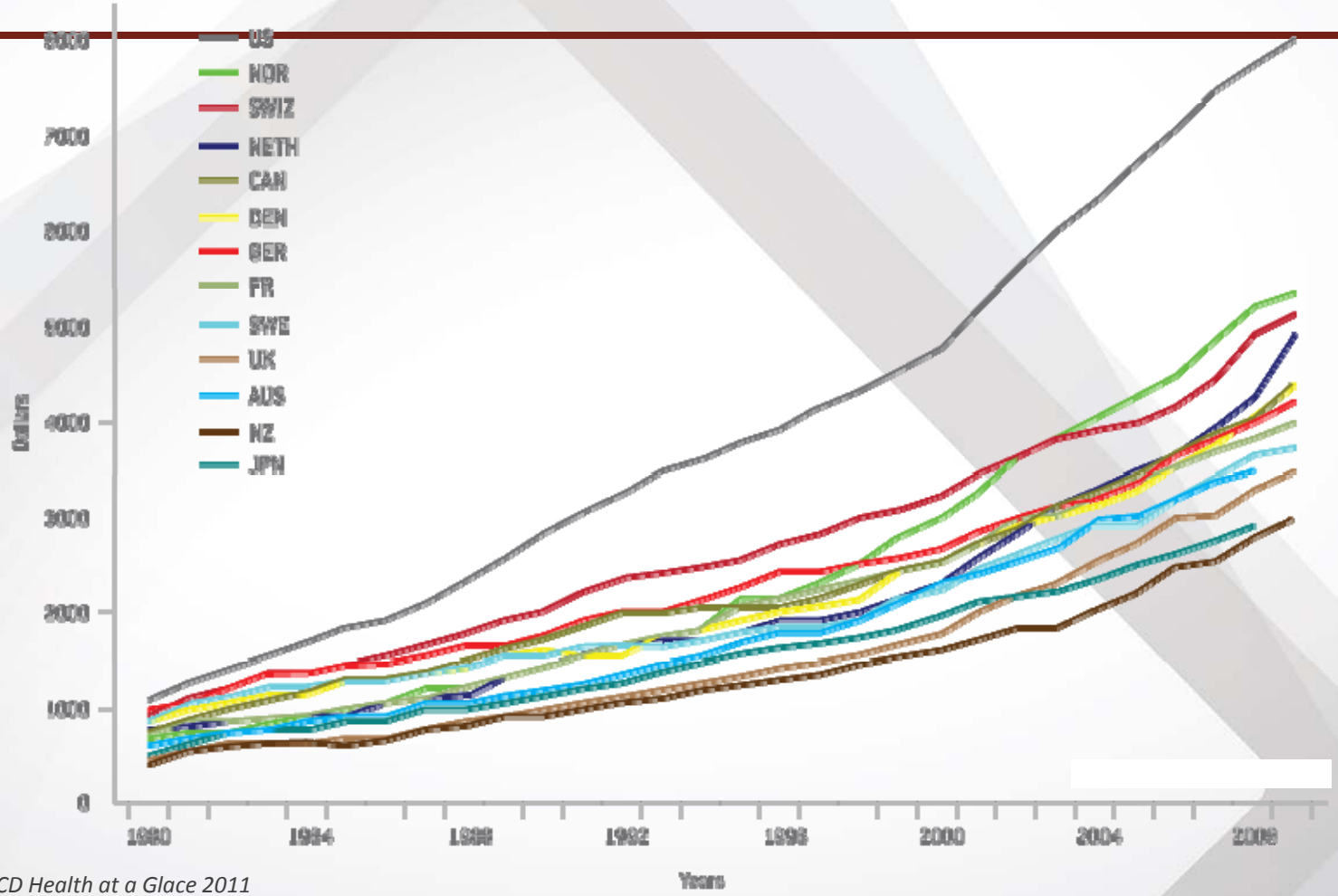


U.S. HEALTH SPENDING ALONE IS LARGER THAN THE GROSS DOMESTIC PRODUCT OF MOST NATIONS

Total health spending in the United States was $2.7 trillion in 2011. If all of that activity was separated into its own sovereign nation, it would constitute the fifth largest economy in the world, behind only the United States, China, Japan, and Germany.

Note: Gross domestic product adjusted for purchasing power parity. Data is for 2011 and from The Organisation for Economic Co-operation and Development (OECD).
Source: D. Blumenthal and R. Osborn, *In Pursuit of Better Care at Lower Costs: The Value of Cross-National Learning*, The Commonwealth Fund Blog, April 2013.

Average health care spending per capita 1980-2009



Source: OECD Health at a Glace 2011

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Exhibit 3. Half of Young Adults Who Lost a Job with Health Benefits from November 2009 to November 2011 Became Uninsured

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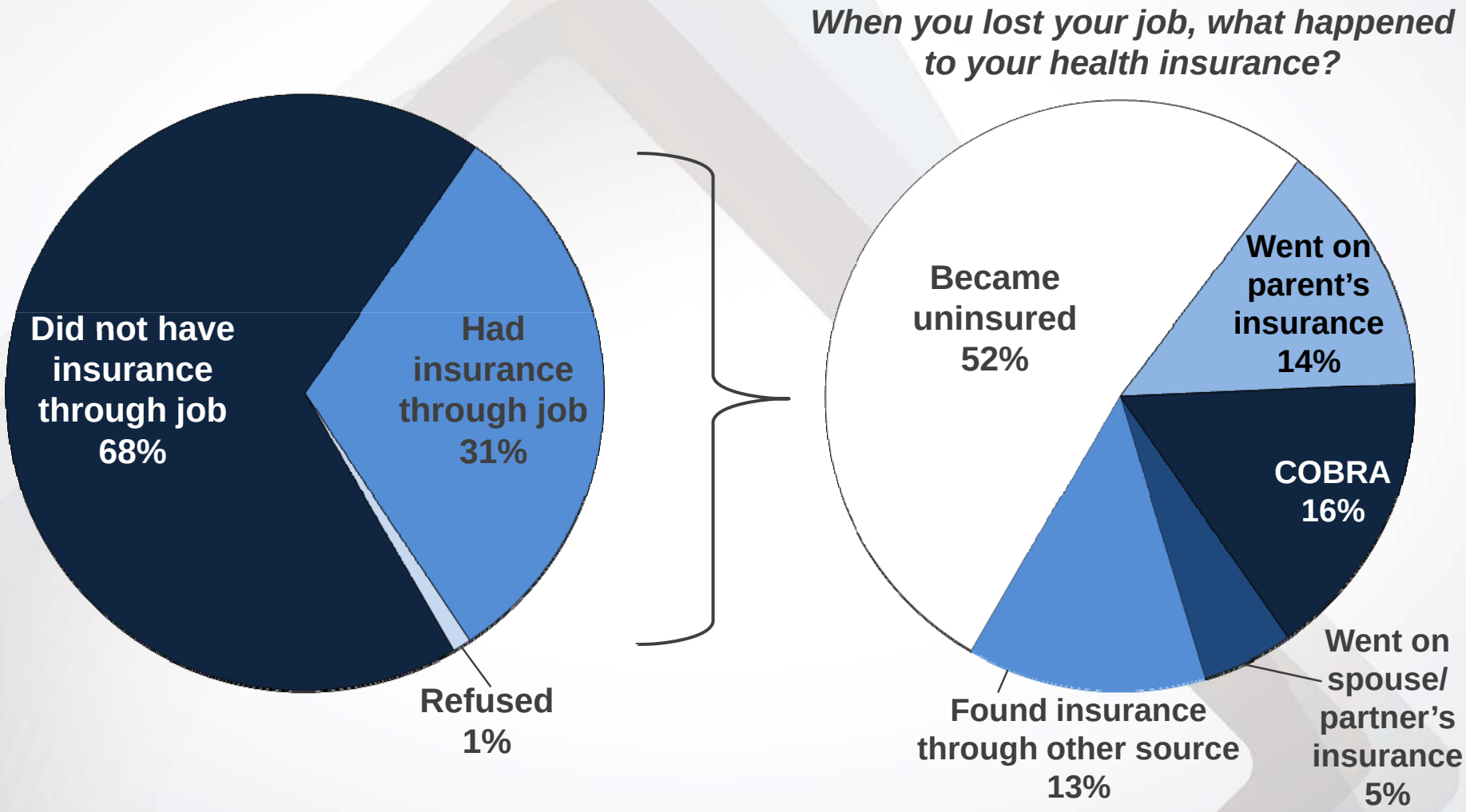

Adults ages 19–29 who lost a job in the past two years

Adults ages 19–29 who had insurance through job

Source: The Commonwealth Fund Health Insurance Tracking Survey of Young Adults, 2011.

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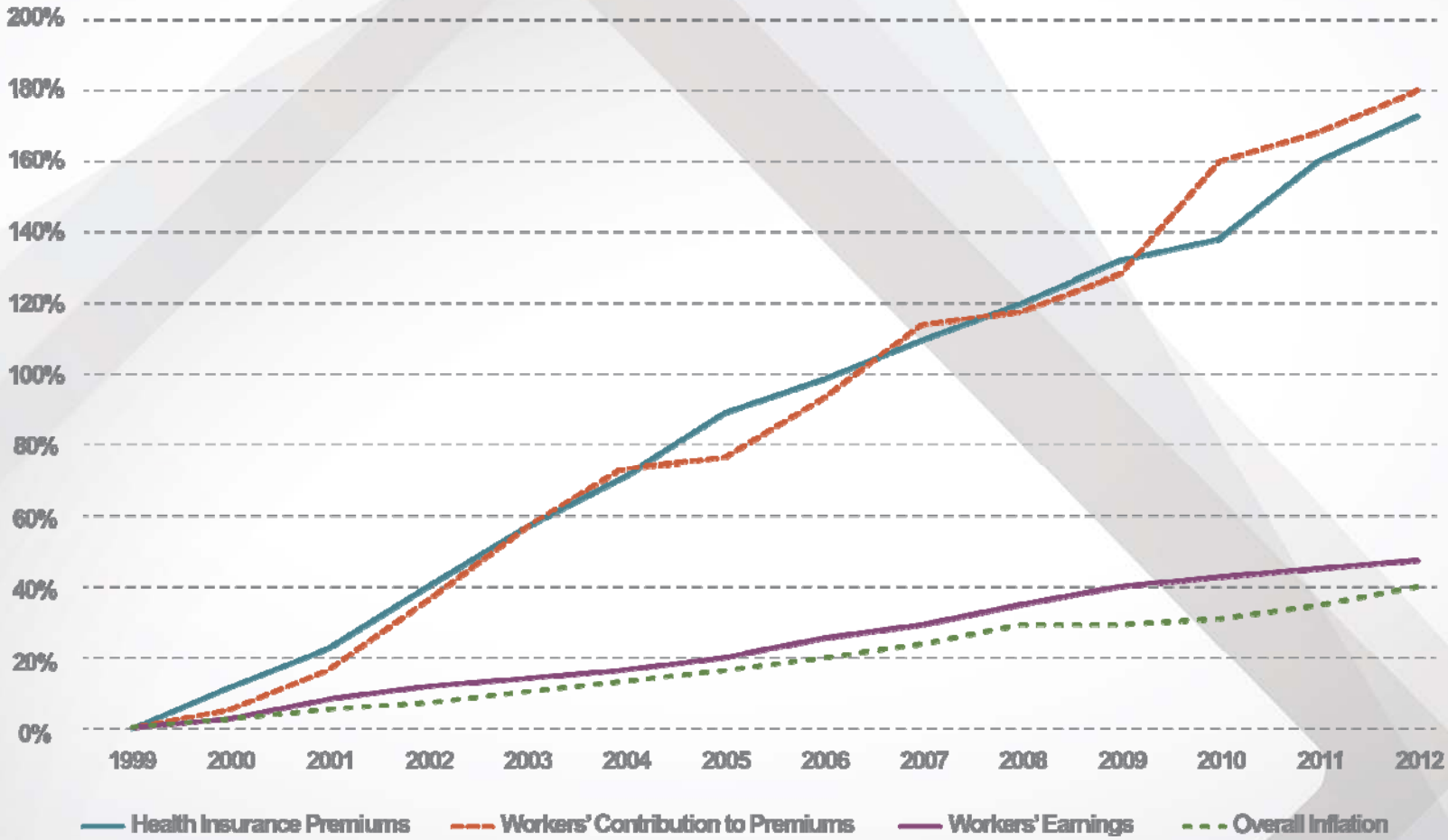
Cumulative increases in health insurance premiums, workers' contributions to premiums, inflation, and workers' earnings, 1999-2012



Source: OECD Health at a Glace 2011

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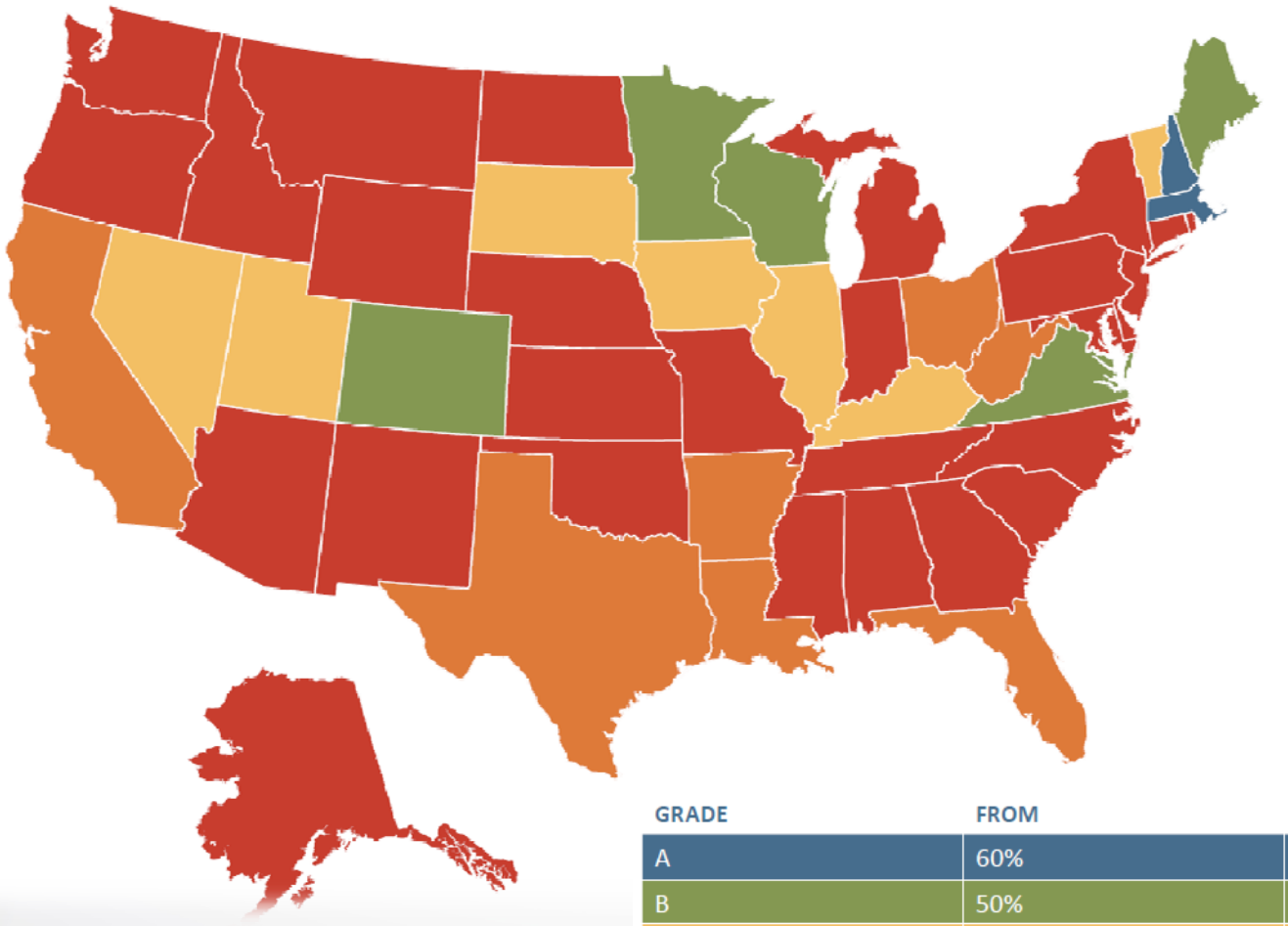
II. 50 STATE REPORT CARD ON PRICE TRANSPARENCY LAWS

Figure 1: Map Overlay



GRADE	FROM	TO
A	60%	100%
B	50%	59%
C	40%	49%
D	30%	39%
F	0%	29%

Catalyst for Payment Reform-Report Card on State Price Transparency Laws 3/18/13

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Patient Centered Medical Home

- Continuing, Comprehensive and Personal Care In The Context Of Family And Community

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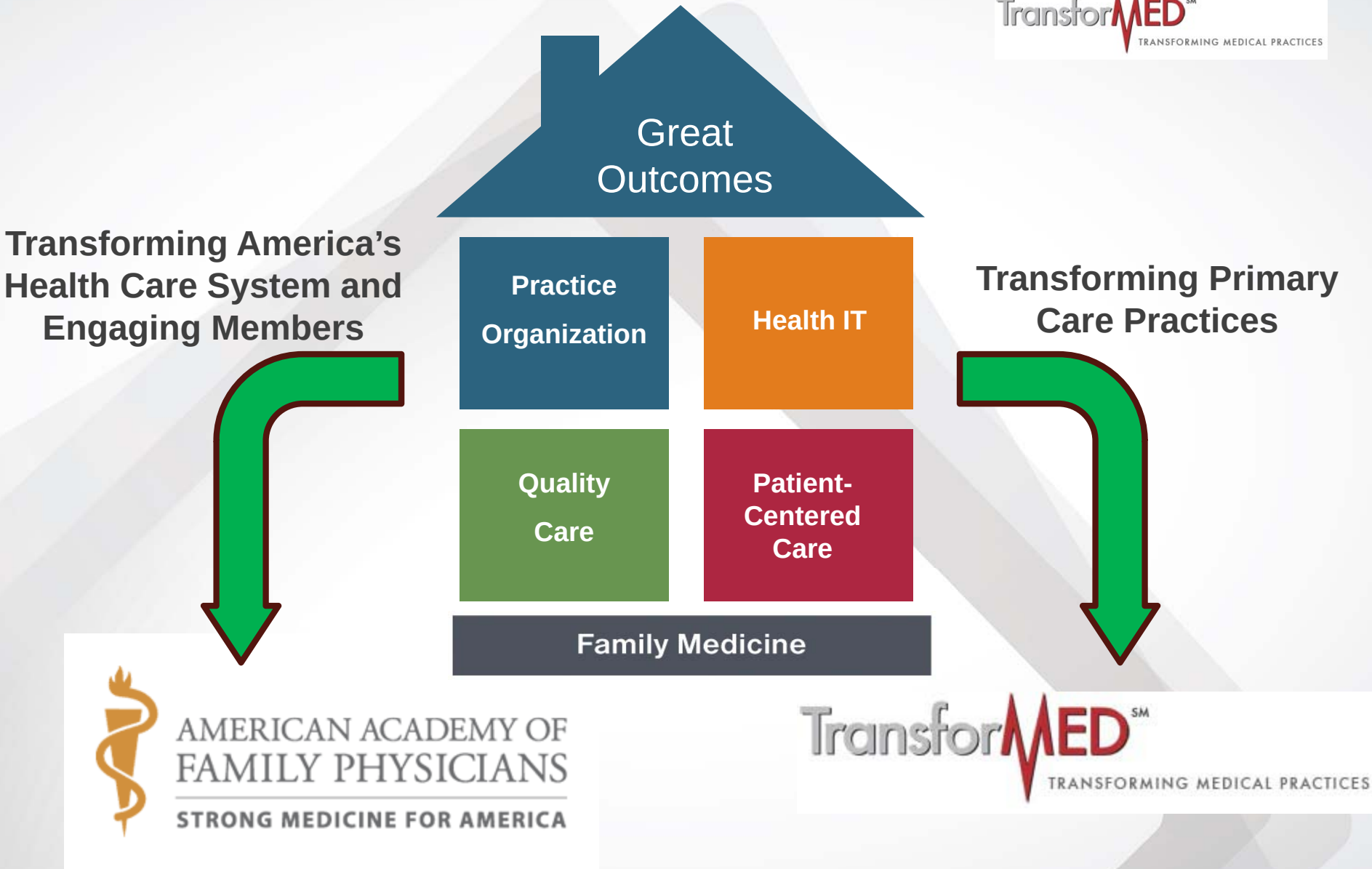

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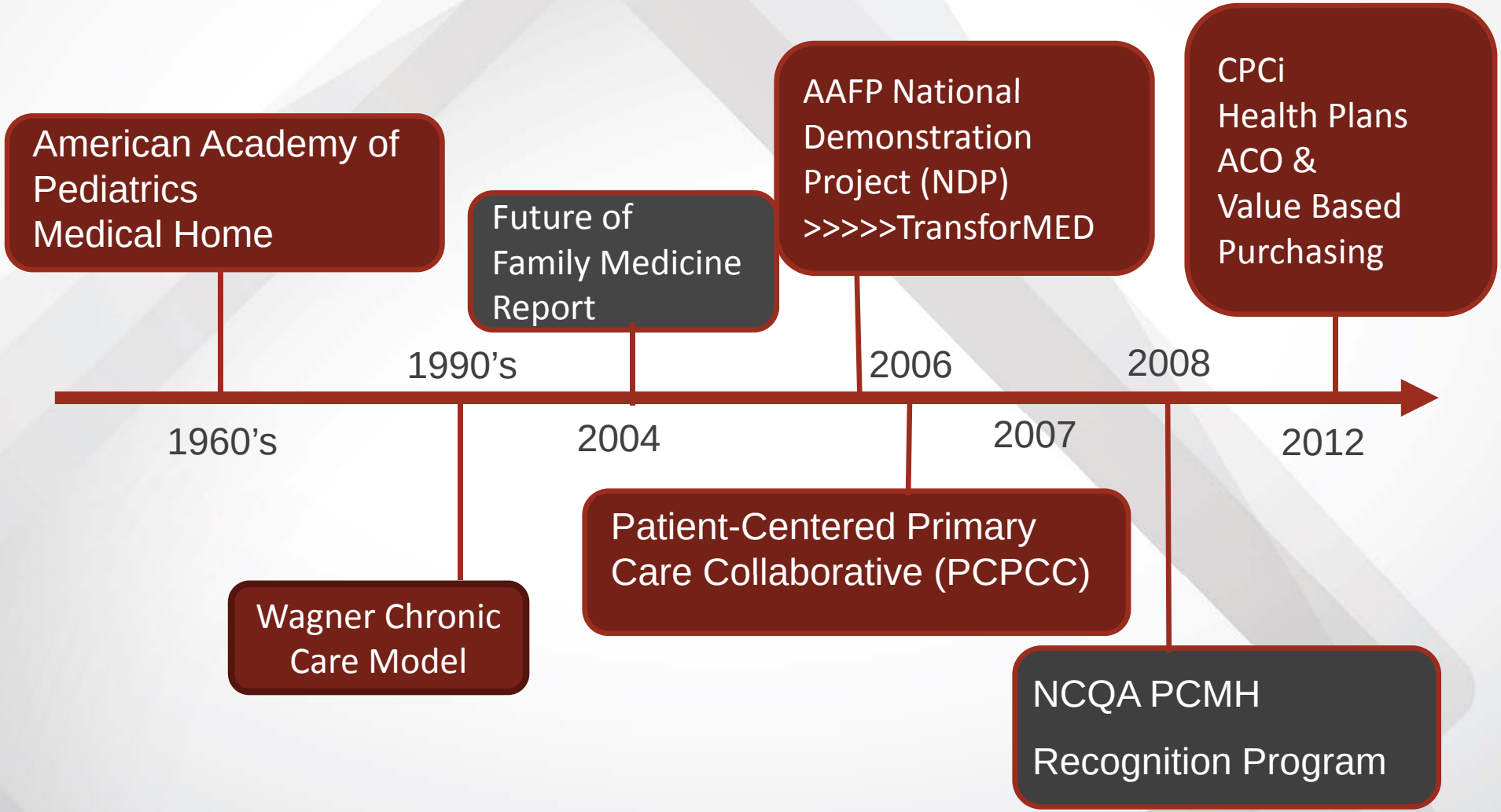
Patient-Centered Medical Home (PCMH)



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Patient Centered Medical Home
Demystified

PCMH is nothing less than an **extreme make-over** for primary care practices, to make them:

- More **Service Oriented** for patients
- More **Effective** for better patient outcomes
- More **Efficient** for better profit
- More **Fun** to go to work for all

Medical

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Patient-Centered Primary Care COLLABORATIVE

Why the Medical Home Works: A Framework

Feature	Definition	Sample Strategies
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
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
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
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.
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

Potential Impacts

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

Providers are less likely to order duplicate tests, labs, or procedures

Better management of chronic diseases and other illness improves health outcomes

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

Health care dollars saved from reductions in use of ER, hospital, test, procedure, & prescriptions.

Critical Elements For PCMH

- True **team** approach to care and change
- Quality measures and a **culture of improvement**
- Patient and family **engagement** with patient self-management support
- Care **management** and care **coordination**
- **IT enabled** for the core business, clinical, education and communication functions

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"Patient Centeredness"

- Patient empowered to participate in **decision making**, how and when they get the care they need
- More than just **patient satisfaction** surveys
- Focus groups or patient advisors on improvement work groups
- Cultural **sensitivity** and awareness
- Unbiased information on **treatment choices**

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Systematic Change In Process

- *For Example:*
  - Install a registry system for common chronic conditions
  - Develop a team approach to care
  - Train staff to provide patient self-management support
  - Install protocols and reminders
  - Integrate a measurement strategy into the everyday care
  - Use evidence based guidelines at POC
  - Set up an interactive patient portal
  - Optimize use of information technology to support the work flow

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Does PCMH We

- F MH hits
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www.pcpcc.net/publications

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Patient Centered Medical Neighborhood

- Creating A Shared Sense Of Responsibility For Cost, Quality And Service

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What are Patient Centered Medical Neighborhoods (PCMN)?

- Medical Home and Medical Neighbors communicate and collaborate with each other to achieve improved care through **clinical integration** and **coordination** within the PCMH care delivery model.
- Align the **interests of all:** patients, physicians, hospitals, outpatient & community services to drive value and outcomes for patients.
- PCMNs are built on a strong foundation of comprehensive and capable **primary care practices** aligned with health systems and specialists to insure that care is coordinated and managed.

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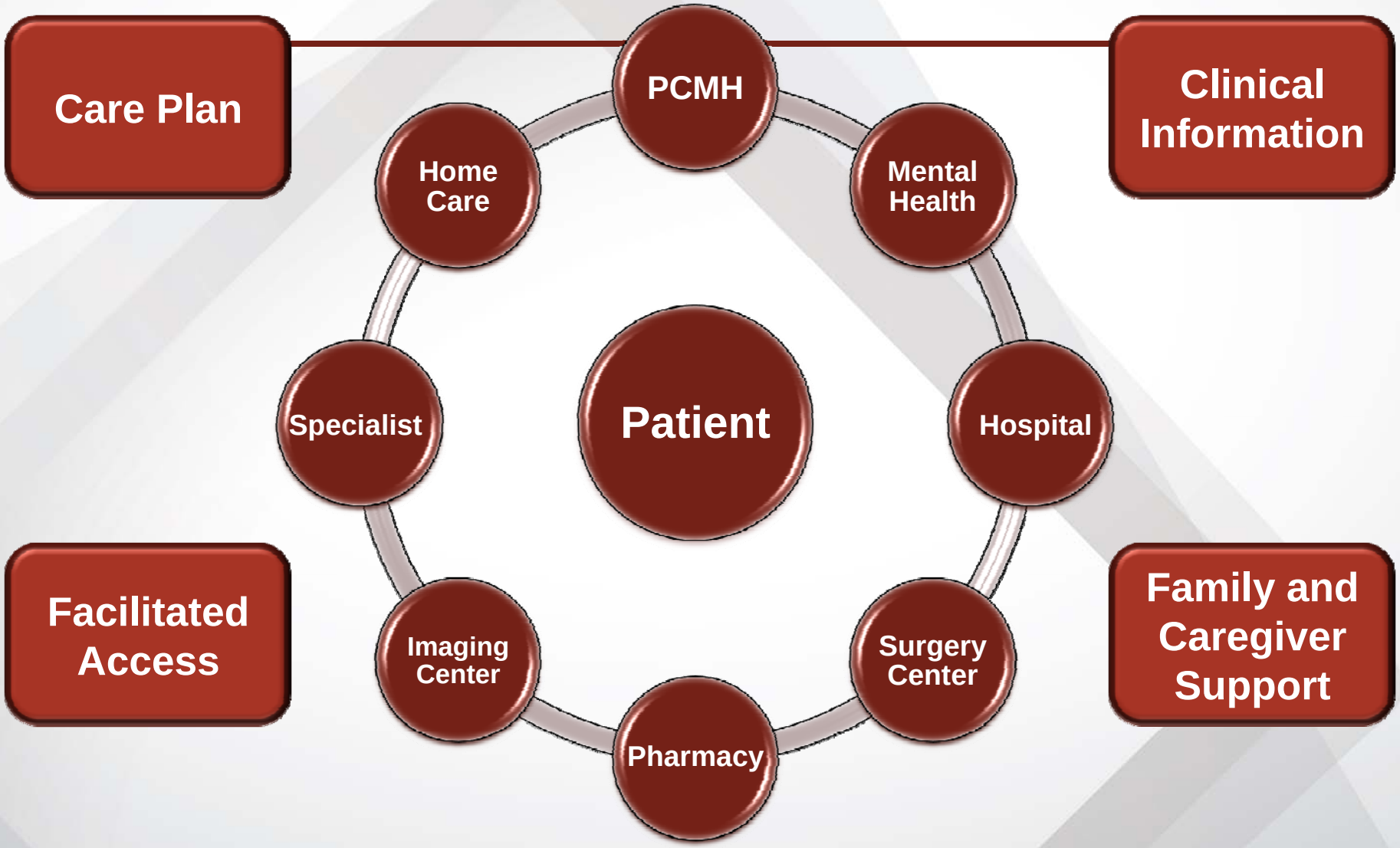
PCMH and PCMN



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Value of the PCMH-N

- Transforming healthcare delivery with an **integrated primary care function**
- **Integrating quality improvement** and **data collection** methods into all practices
- Incorporating **population-based strategies** for care management
- Developing and applying strategies to expand and sustain **improvements** to care
- Increasing **efficiency and satisfaction** for both patients and the healthcare team
- Enhanced **outcomes** and **quality** improvements

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Criteria For Good Citizenship In The Neighborhood

- **Shared responsibility** for cost, quality and service
- Willingness to **discuss** process and interactions
- Efficient **transfer** of clinical information
- Multi-level **accessibility**
- Commit to a high level of **service**
- The **patient** is always the central focus

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PCMH Role

- Patient advocate
- Central repository of personal health information
- Center for preventive services and wellness advice
- Comprehensive care
- Continuity of care
- Care management
- Care coordination
- Integrator

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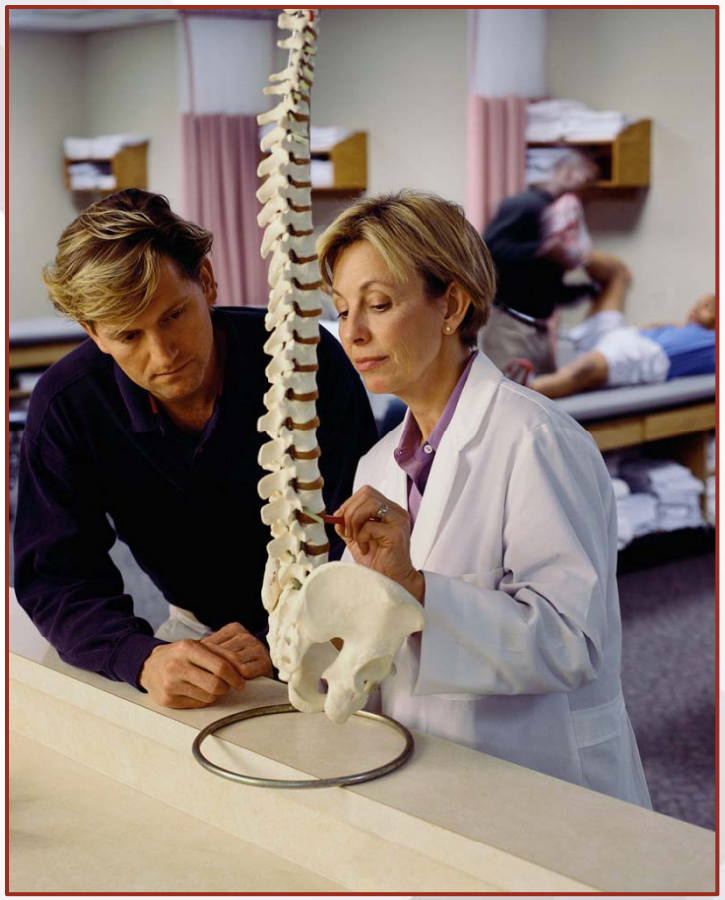
Sub-Specialty Care Role

- Special expertise in knowledge and/or procedures
- Timely access that matches the patient need
- Recommend changes in the care plan
- Partner with primary care



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Emergency Room Role

- Triage level of intervention required
- Get clinical and health status information from PCMH
- Be aware of community capabilities for follow up

- Appropriate use of hospitalization
- Offer definitive testing
- Return of care to PCMH

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Hospital Role

- Acute care
- Access to specialty services
- Specialized equipment not available elsewhere
- Surgical support
- Safe return to community of care

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Administration Role

- Leadership
- Governance
- Data transfer support
- Financial health
- Allocation of resources
- Appropriate incentives
- Support integration
- Communication

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Community Resources Role

- Education
- Support groups
- Behavioral health
- Healthy community
- Family/caregiver support
- Volunteerism

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Accountable Care Organizations

- Clinical, Financial And IT Integration For Better Care, Better Quality And Better Service

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Accountable Care Organization

A group of providers who agree to take on a shared responsibility for the cost and quality of the health care provided to a defined population of patients

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Complex Adaptive Systems

- There is little argument that our health care delivery in the US is a complex adaptive system
- While there is a wide variety of actors, individual behaviors are governed by a few simple rules
- We are about to see dramatic changes in the response of these actors because of changes in the simple rules
- No one can fully predict what will happen!

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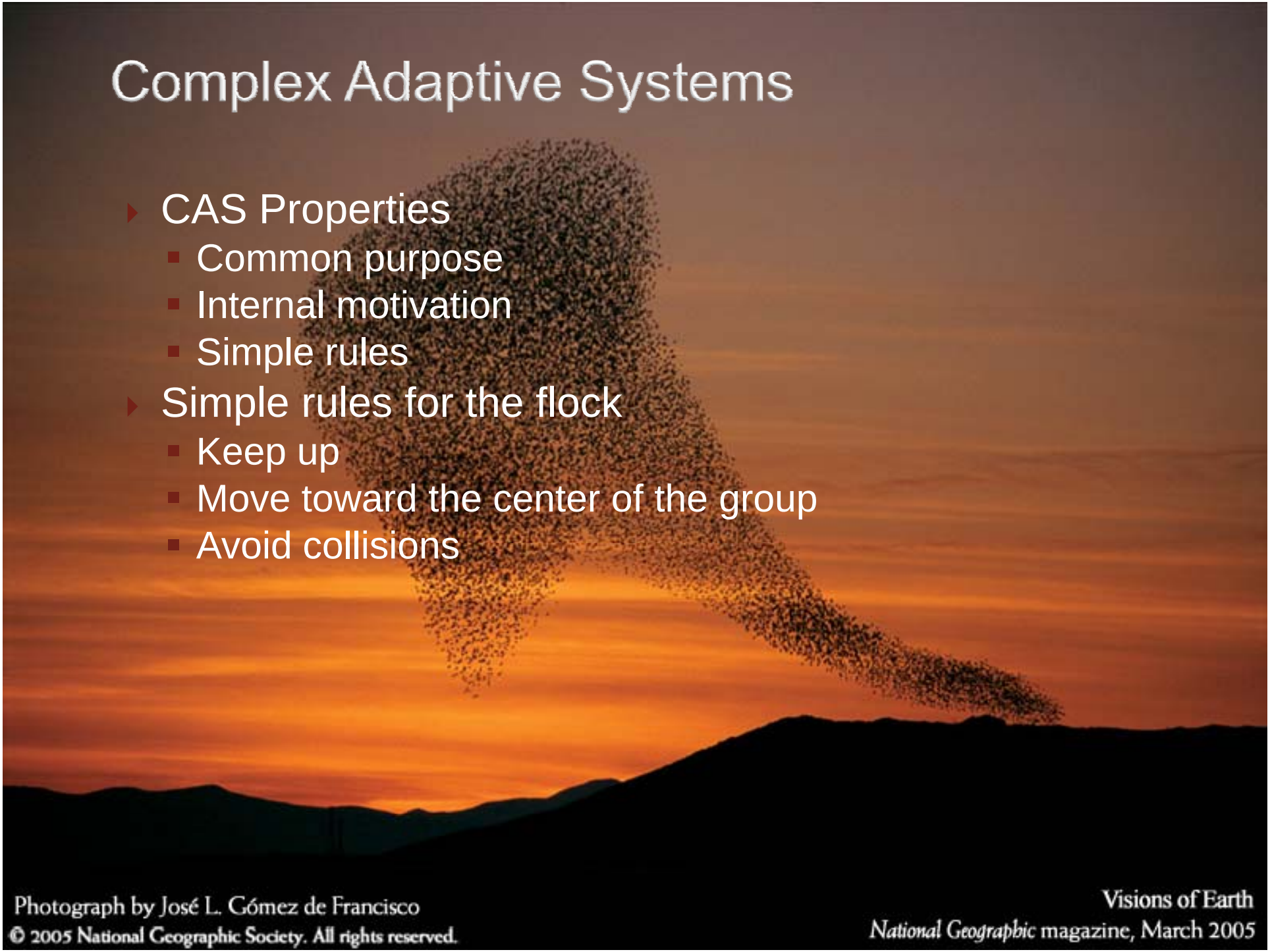
Complex Adaptive Systems

- CAS Properties
  - Common purpose
  - Internal motivation
  - Simple rules
- Simple rules for the flock
  - Keep up
  - Move toward the center of the group
  - Avoid collisions



Photograph by José L. Gómez de Francisco

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Visions of Earth

National Geographic magazine, March 2005

Complex Adaptive System-Health Care

- Common Purpose
  - Individual health, population health, sustainable cost (Triple Aim)
- Internal Motivation
  - Altruism/Professionalism, financial success and stability, community good
- Simple Rules
  - For the health care system
  - For ACOs

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Crossing the Quality Chasm

"A New Health System for the 21st Century"

- Our common purpose as a health system is that the care should be:
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable

Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System of the 21st Century. Washington: National Academy Press, 2001.

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Health Care Redesign Simple Rules

- Care based on continuous healing relationships
- Customization based on patient needs and values
- The patient as the source of control
- Shared knowledge and free flow of information
- Evidence-based decision making
- Safety as a system property
- Need for transparency
- Anticipation of needs
- Continuous decrease in waste
- Cooperation among clinicians

Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System of the 21st Century. Washington: National Academy Press, 2001.

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Accountable Care Organization Aims

- Safe, effective care for individual patients
- Commitment to the health of the community
- Efficient systems that reduce waste
- Shared responsibility for cost and quality
- Long term financial viability

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ACO Simple Rules

- Patient engagement and partnership
- Align payment and incentives with aims
- Primary care is central and capable
- Culture of quality improvement
- Clinical, financial and IT integration
- Designed for the long term

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Patient Engagement And Partnership

- Patients must be encouraged to choose and use a PCMH
- Center of care coordination
- Family/care-giver involved
- Self-management support
- Superb access to care
- Continuity over time

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Align Payment Incentives With Aims

- Pay for what you want to happen
- Payment and incentives should foster integration and cooperation
- Reward quality and outcomes
- Support infrastructure to accomplish the goals

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Primary Care Is Central And Capable

- Primary care is supported and valued by the system
- Accessible
- Comprehensive
- Continuity assured
- IT enabled
  - Clinical information
  - Communications
  - Education and outreach
  - Financial data

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Culture Of Quality Improvement

- Performance **measurement** is routine
- **Systems** approach to improvement
- Quality **goals** known to all
- **Team** work is the norm
- Patient **outcomes**
- **Service** oriented

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Clinical, Financial And IT Integration

- Must eliminate **fragmentation and waste**
- Internal financial **incentives** are key
- Platform for **data** exchange
- Efficient management
- Service agreements

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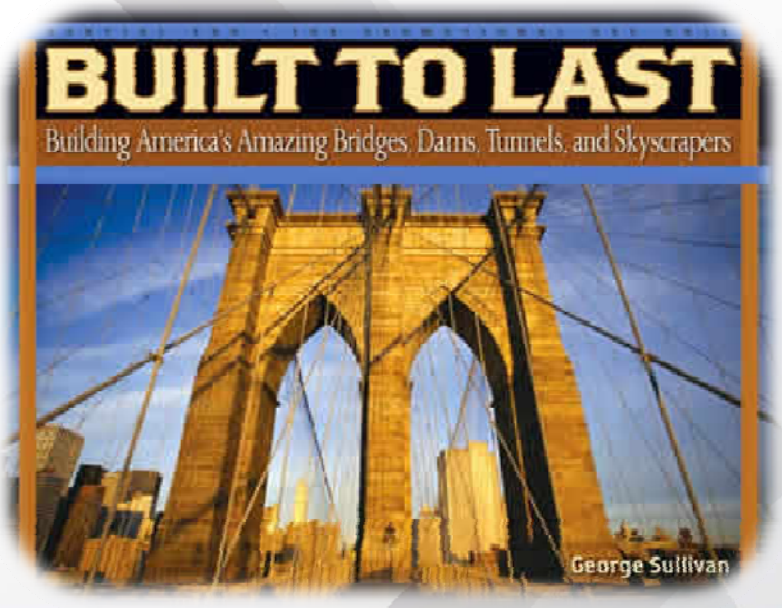
Designed For The Long Term

- ACOs must be set up for the right reasons
- Strong organizational integrity
- Optimize outcomes of care
- Community orientation
- Shared governance
- Patient centered



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CMMI Accountable Care Pilots

Medicare Shared Savings ACO

- Accountable, coordinated care for Medicare FFS beneficiaries…Retrospective analysis of claims data for attribution, cost and quality

Pioneer ACO

- As above but moves sooner in program from FFS to partial global payment

Advanced payment ACO

- Designed for small or rural practices with some monetary advance on expected savings to help with up-front capital costs.

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Increasing Pressure From All Quarters

- More reliance on systems and IT
- More use of metrics for improvement and accountability
- Clinical, financial and IT integration
- Team Care-both the office team and the larger community team
- Care not necessarily only related to visits but more broadly to “access”

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Community Leadership and Public Health

- **Health And Well-Being Is Not All About Health Care**

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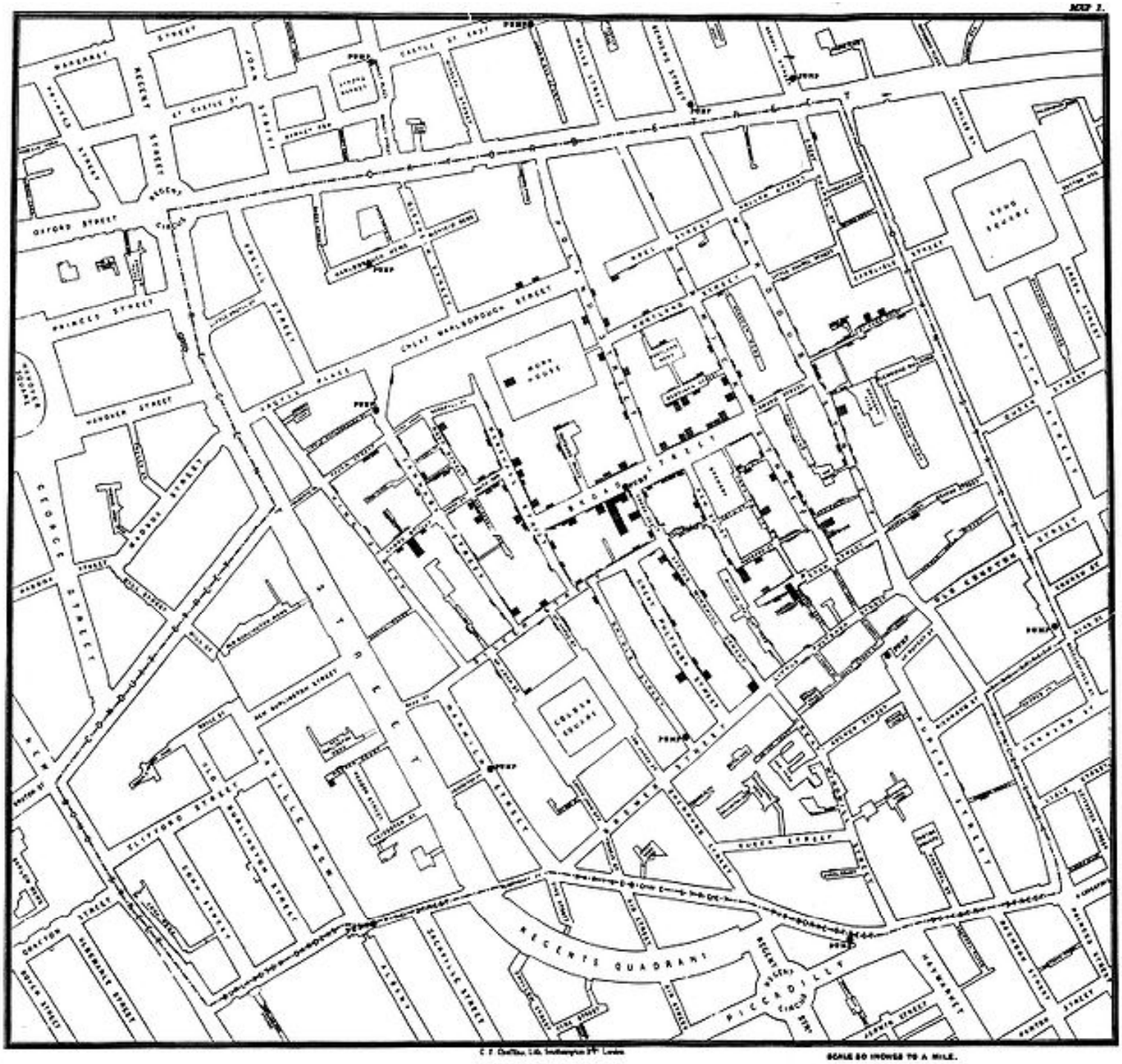

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London-1854

John Snow's Original Map Showing The Concentration Of Cholera Cases Around The Broad Street Pump
-Wikipedia

Public Health And Primary Care

- How can we refocus on health rather than health care?
- Which problems respond better to a public health approach?
- What portion of our healthcare dollar should go to public health?

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Public Health-IOM Definition

- In its 1988 landmark report and again in 2003 in an updated report, Institute of Medicine defined **public health** as:

"What we as a society do to collectively assure the conditions in which people can be healthy."

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Measures Of Population Health

- Healthways/Gallup Organization continuing poll of health and well-being
- Agency for Healthcare Research and Quality (AHRQ) community measures
- CDC Obesity rates

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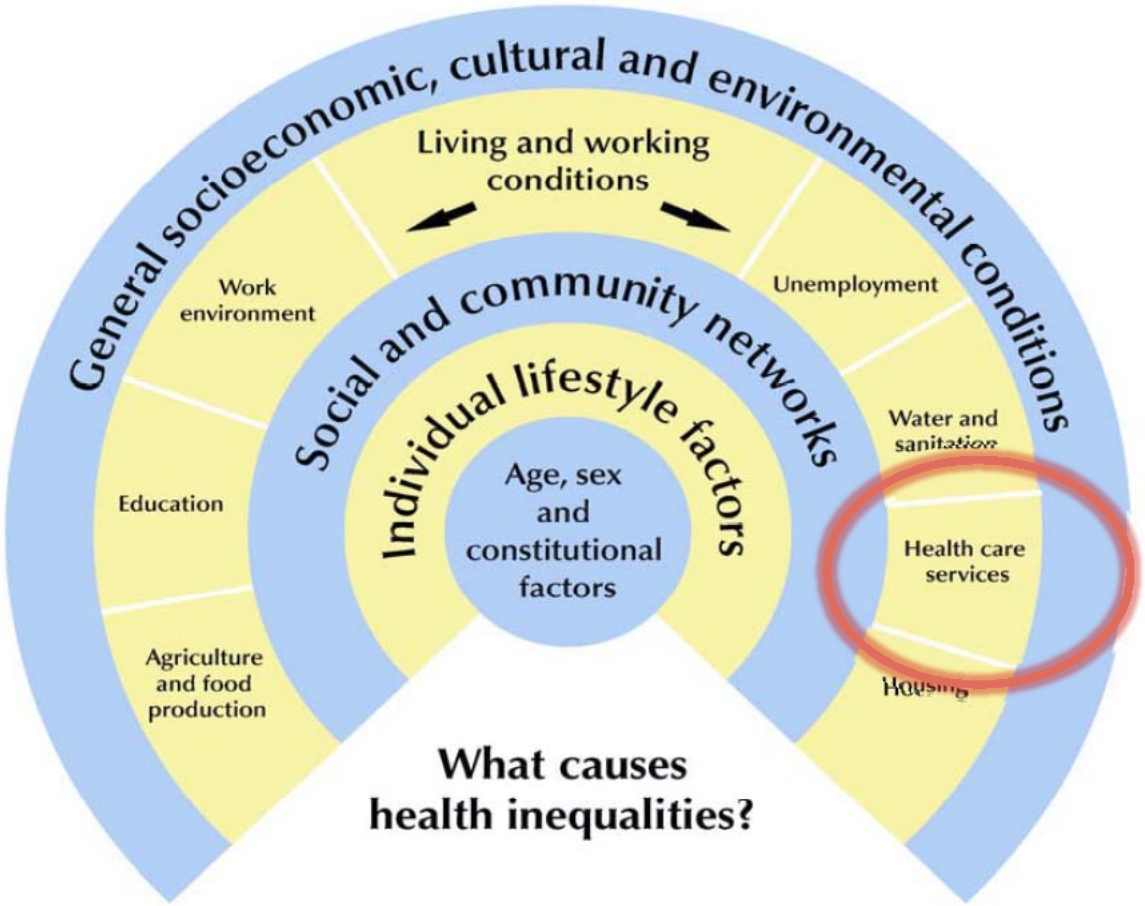
The Social Determinants of Health

Fig. 1. The interacting determinants of health



World Health Organization, September 2012 Malta Regional Meeting

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MEASURES

- Overall State Ranking
- Air Pollution
- Binge Drinking
- Cancer Deaths
- Cardiovascular Deaths
- Children in Poverty
- Diabetes
- Geographic Disparity
- High School Graduation R...
- Immunization Coverage
- Infant Mortality

*Supplemental Measures

United Health Foundation 2012 Annul Report

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State-Wide Health And Well-Being Goal

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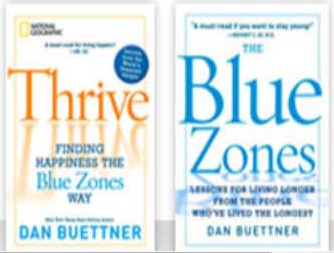

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Conclusions

- The Health and well-being of our people is a community responsibility
- Health care is only a small determinant of the health of our population
- Finding synergy between public health and primary care approaches is critical to solving our most pressing chronic disease problems…obesity, inactivity and smoking

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