

Medical Homes, Medical Neighborhoods, and the Transformation of Health Care

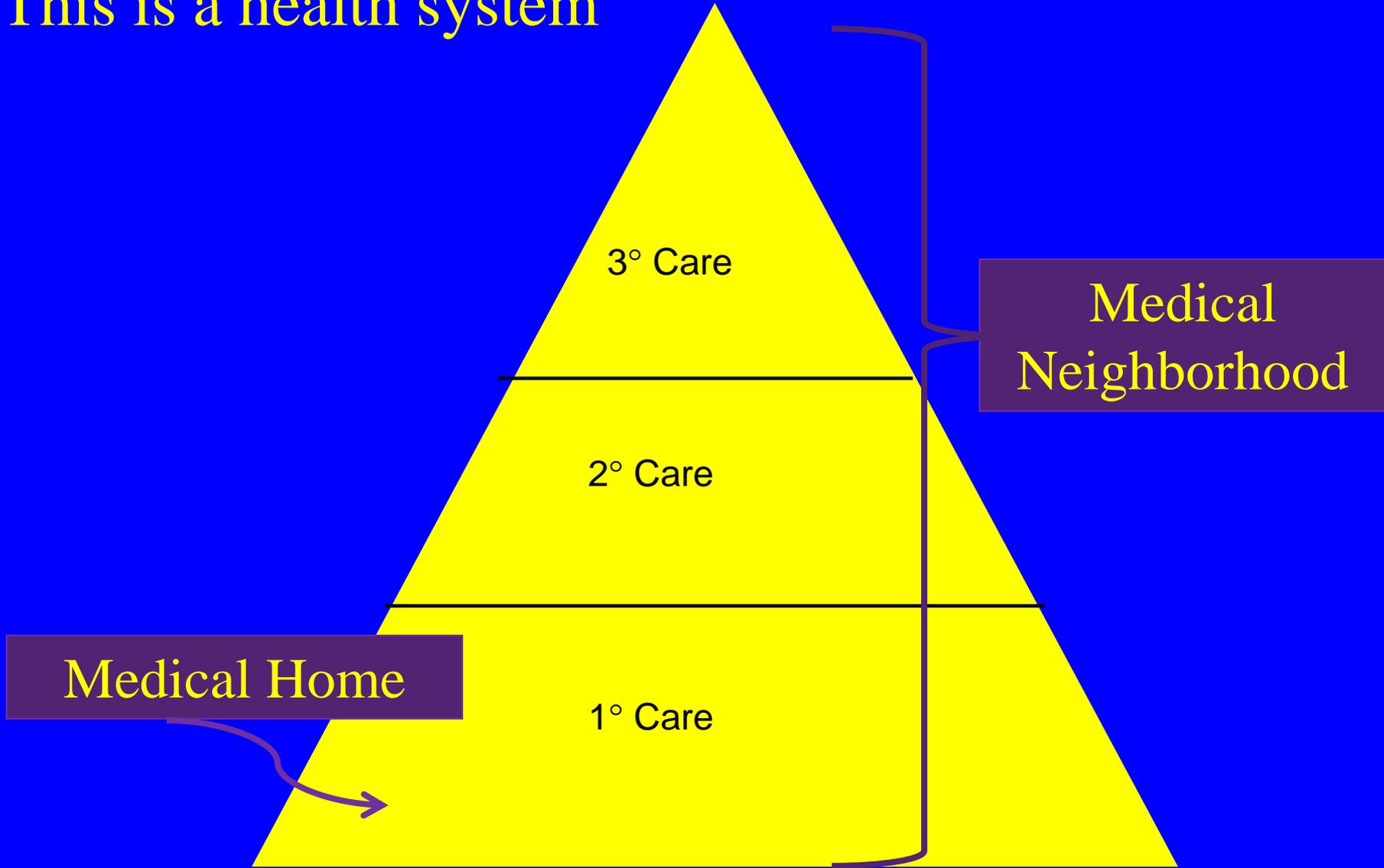
Vermont Blueprint for Health
April 9, 2014

Kevin Grumbach, MD

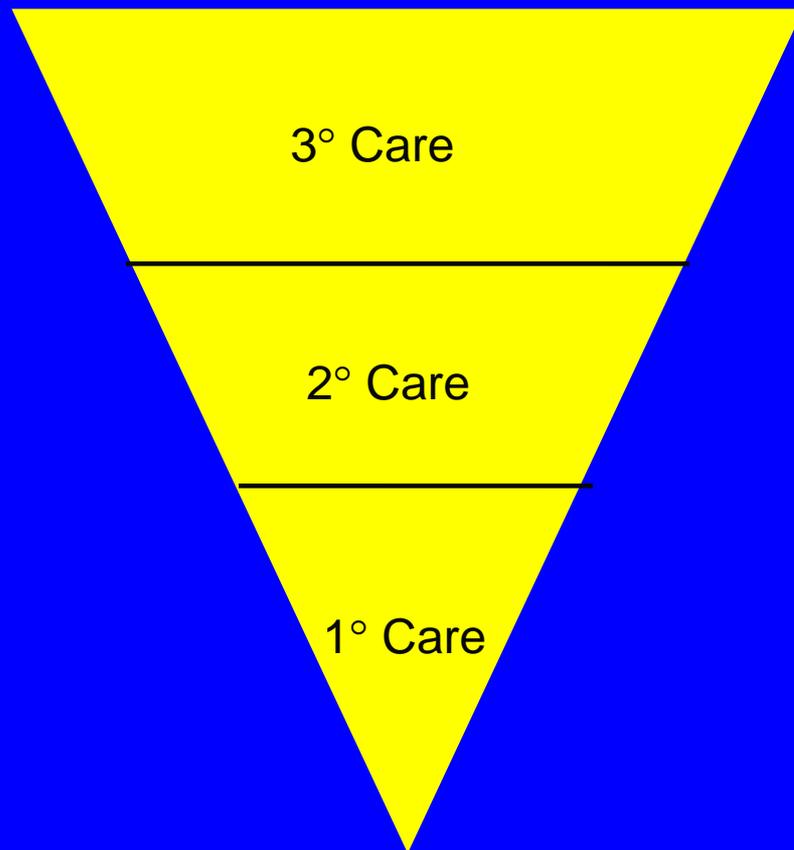
Center for Excellence in Primary Care
Department of Family & Community Medicine
University of California, San Francisco



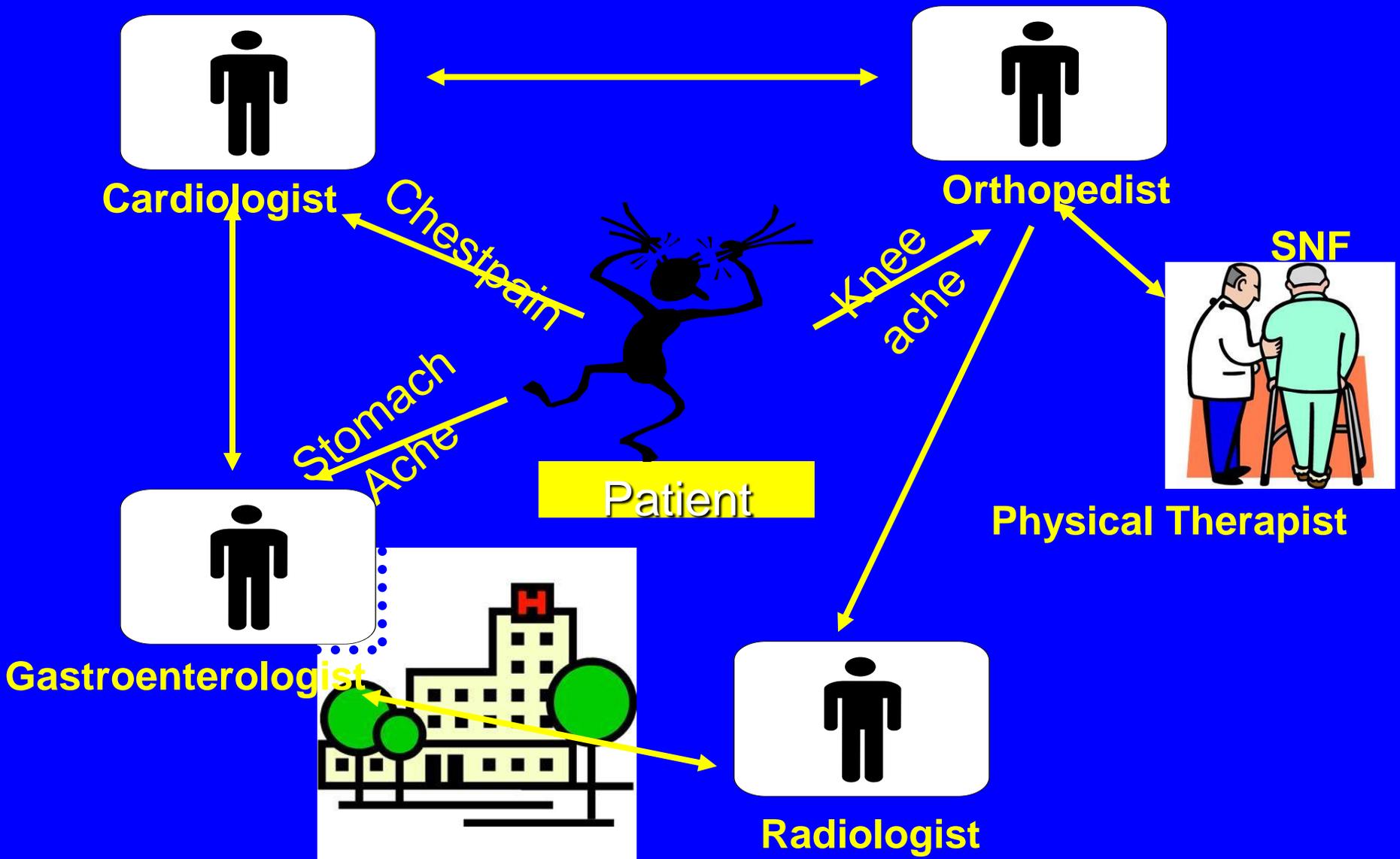
This is a health system



Tom Daschle, testifying to Senate Health Committee, Jan 2009:
“Every country starts at the base of the pyramid with primary care, and they work their way up until the money runs out. We start at the top of the pyramid, and we work our way down until the money runs out...And so we have to change the pyramid. We have to start at the base.”



Health Care: A Perilous Journey*



*From Tom Bodenheimer, NEJM 2008;358(10):1064

VT Blueprint Annual Report 2013

“a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.” (accents added)

VT Blueprint Assets

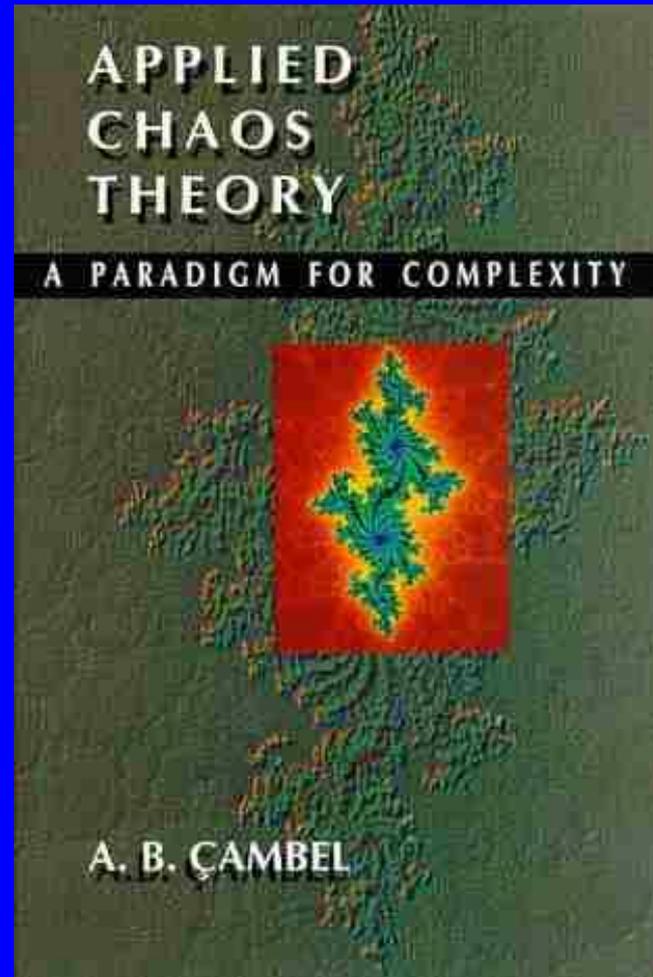
- Advanced primary care models (PCMH)
- Community Health Teams
 - Vermont Chronic Care Initiative
 - Support and Services at Home
 - Integrated addiction medicine-primary care
- Practice coaches (Primary Care Extension Program)
- Aligned payers
 - Payment
 - Data



Some Reflections

- Advanced primary care is a journey, not a destination
- From the triple aims to the quadruple aims: attention to the primary care workforce
- Advanced medical neighborhoods and ACOs
- Beyond a medical model of population health: integrating health care and public health

Making change in complex adaptive organizations is difficult



The Report Card Syndrome

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity		Pts
A.	Access During Office Hours**	4
B.	After-Hours Access	4
C.	Electronic Access	2
D.	Continuity	2
E.	Medical Home Responsibilities	2
F.	Culturally and Linguistically Appropriate Services	2
G.	Practice Team	4
		20
PCMH2: Identify and Manage Patient Populations		Pts
A.	Patient Information	3
B.	Clinical Data	4
C.	Comprehensive Health Assessment	4
D.	Use Data for Population Management***	5
		16
PCMH3: Plan and Manage Care		Pts
A.	Implement Evidence-Based Guidelines	4
B.	Identify High-Risk Patients	3
C.	Care Management**	4
D.	Manage Medications	3
E.	Use Electronic Prescribing	3
		17

PCMH4: Provide Self-Care Support and Community Resources		Pts
A.	Support Self-Care Process**	6
B.	Provide Referrals to Community Resources	3
		9
PCMH5: Track and Coordinate Care		Pts
A.	Test Tracking and Follow-Up	6
B.	Referral Tracking and Follow-Up**	6
C.	Coordinate with Facilities/Care Transitions	6
		18
PCMH6: Measure and Improve Performance		Pts
A.	Measure Performance	4
B.	Measure Patient/Family Experience	4
C.	Implement Continuously Quality Improvement**	4
D.	Demonstrate Continuous Quality Improvement	3
E.	Report Performance	3
F.	Report Data Externally	2
		20

****Must Pass Elements**

NCQA PCMH status of 46 LA Community Health Centers and Quality of Diabetes Care

	NCQA PCMH Level 1	NCQA PCMH Levels 2-3
HgbA1C checked last 12 months	84%	84%
LDL checked last 12 months	70%	72%
HgbA1C <8	59%	57%
LDL <100	54%	49%

%s adjusted for underlying differences between CHCs

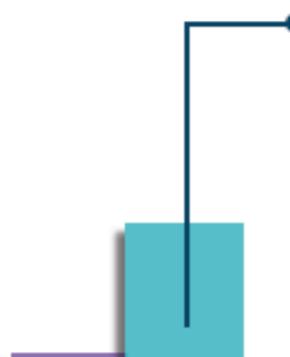
Source: Clarke RMA et al. Tool Used To Assess How Well Community Health Centers Function As Medical Homes May Be Flawed. Health Affairs 2012; 31(3):627-635

“A multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA certification, was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years.”

Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care

Mark W. Friedberg, MD, MPP^{1,2,3}; Eric C. Schneider, MD, MSc^{1,2,3,4}; Meredith B. Rosenthal, PhD⁴; Kevin G. Volpp, MD, PhD^{5,6,7,8,9}; Rachel M. Werner, MD, PhD^{5,7}

[\[+\] Author Affiliations](#)



The Patient- Centered Medical Home's

PCMH studies continue to demonstrate impressive improvements across a broad range of categories including: cost, utilization, population health, prevention, access to care, and patient satisfaction, while a gap still exists in reporting impact on clinician satisfaction.



An Annual Update
of the Evidence,
2012-2013

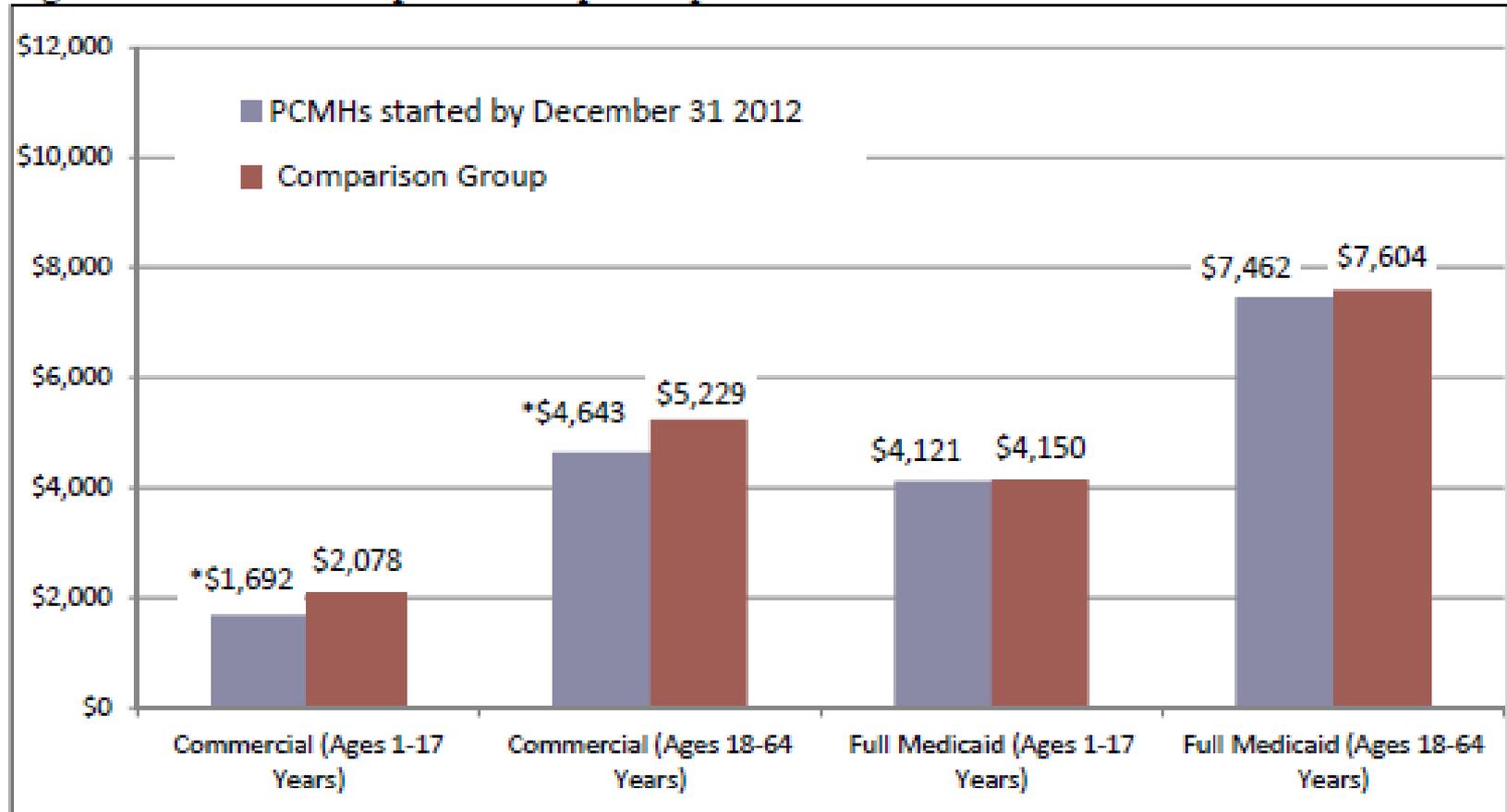
January 2014

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VT Blueprint 2013 Annual Report

Figure 2. 2012 Total Expenditures per Capita



* Blueprint is significantly different from the Comparison group at the 95% confidence level.

Developing the building blocks of the high-performing primary care practice



- We visited 23 high performing practices
- Intensive visits to 7 West Coast practices
- Discussions/observations of clinicians, RNs, MAs, front desk
- The practices look different from the outside but similar inside
- From our observations, we extracted 10 Building Blocks -- the foundation of these practices
- The Building Blocks are a guide to improvement for primary care
- Similar to Safety Net Medical Home Initiative change concepts

10 Building Blocks of High-Performing Primary Care



T Bodenheimer et al AnnFamMed March 2014

10 Building Blocks of High-Performing Primary Care

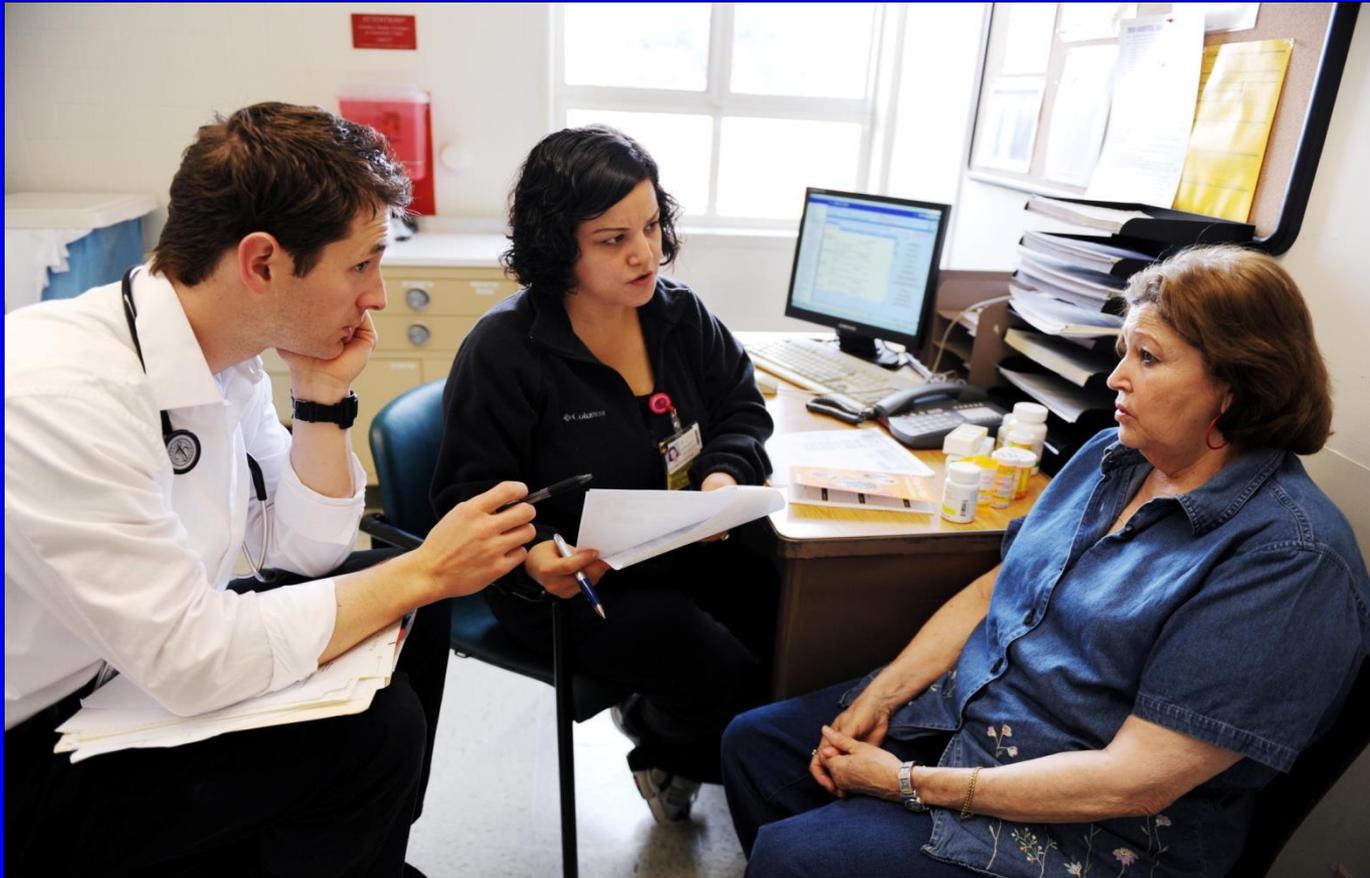


T Bodenheimer et al AnnFamMed March 2014

Right People on the Team Operating at Top of Their Skills With Teamwork

- Team structure
 - Personnel and positions
 - Stable teamlets
- Team culture
 - Culture shift
 - Co-location
 - Defined workflows and roles – workflow mapping
 - Standing orders/protocols
 - Training, skills checks, and cross training
 - Ground rules
 - Communication – huddles, meetings, constant interaction

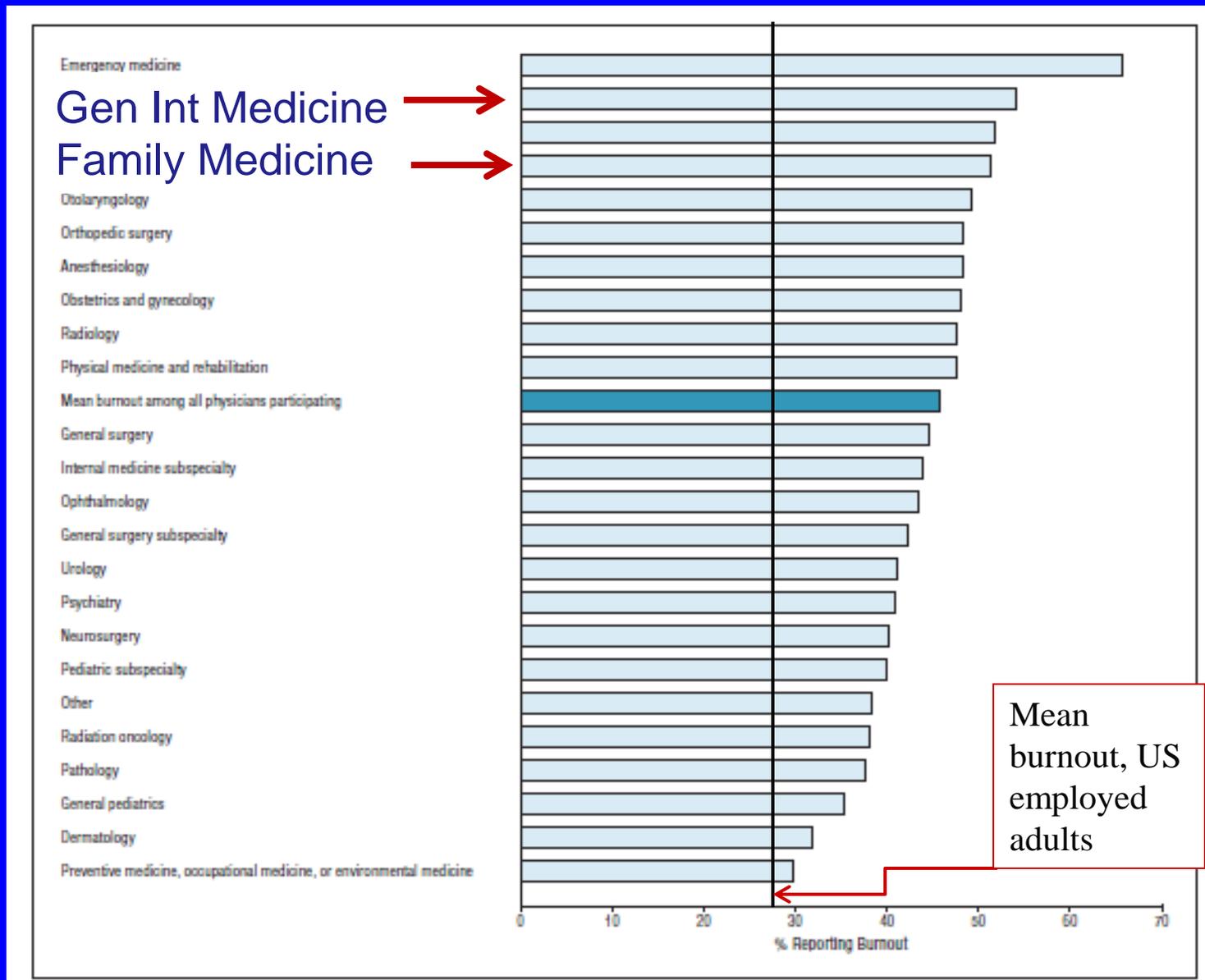
It Takes a Team to Make Primary Care Work



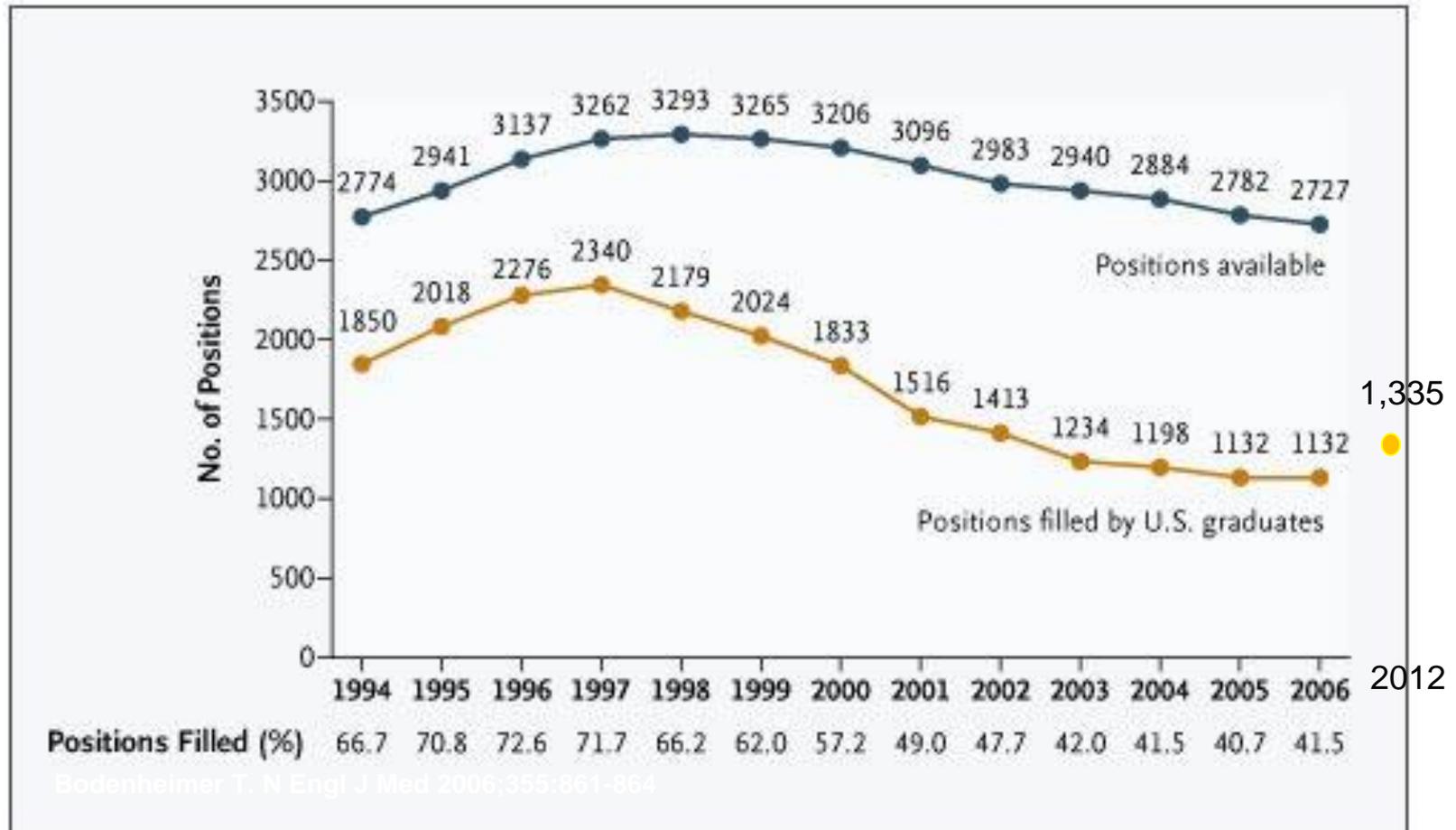
A primary care physician with a panel of 2500 average patients would spend:

- 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)

Burnout By Specialty



Family Medicine Residency Positions and Number Filled in Match by U.S. Medical School Graduates



The Choice

- Teams
- Concierge Medicine



The ~~Triple~~ Aims Quadruple

- Better patient experience
- Better health
- Lower cost
- Joyful and sustainable careers in primary care

Team structure and culture are associated with lower burnout in primary care practices

*R Willard-Grace, D Hessler,
E Rogers, K Dubé,
T Bodenheimer, K Grumbach*



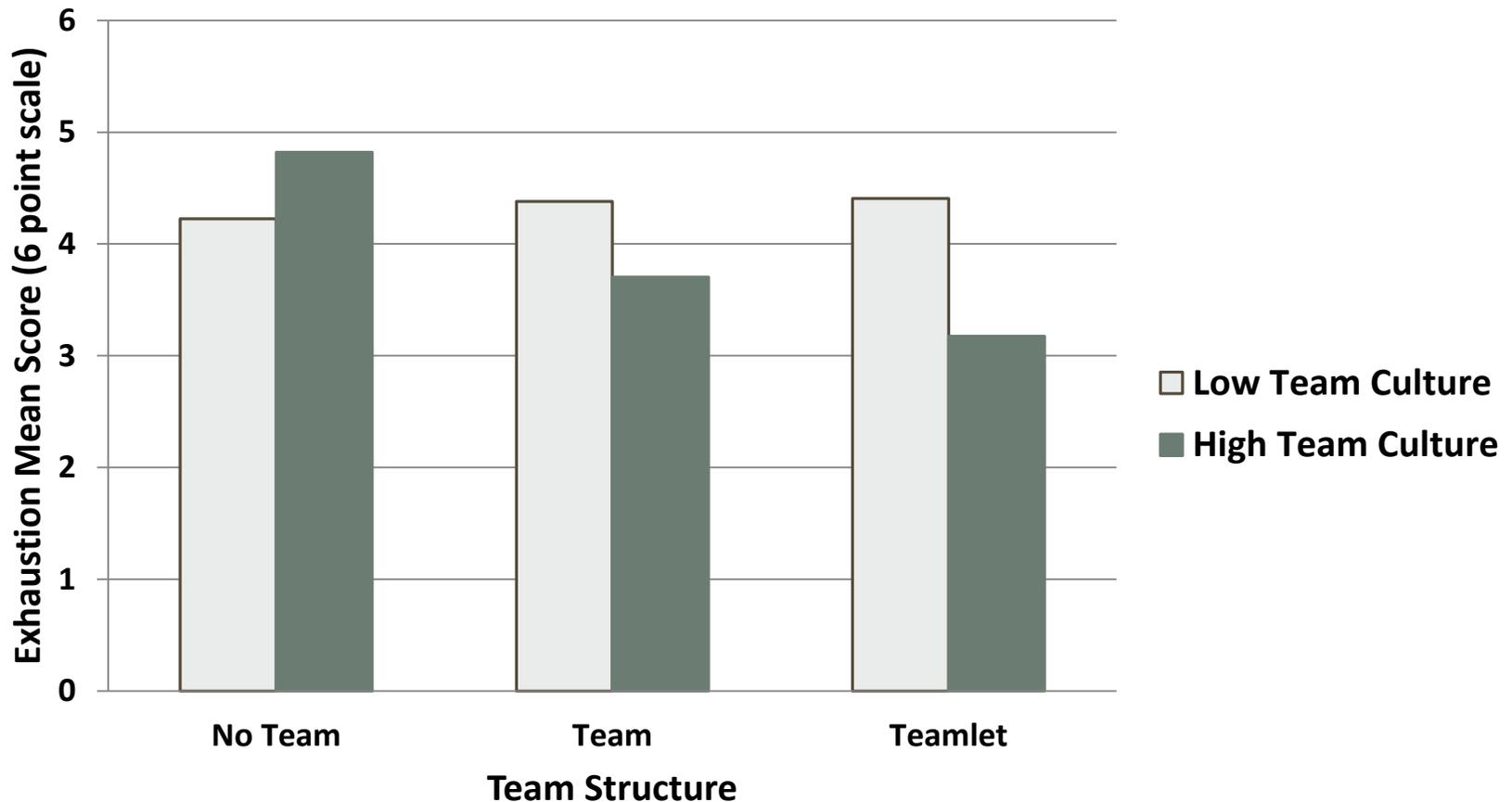
Copyright 2012 UCSF Center for Excellence in Primary Care

Journal of the American Board of Family Medicine, March 2014

Study Design & Methods

- 16 San Francisco primary care clinics (DPH and UCSF)
- Survey measures:
 - Maslach Burnout Inventory (MBI) (outcome)
 - One-item measures of team structure (predictor)
 - Seven-item measure of team culture developed by study team (predictor)
- GEE modeling to account for clustering at clinic level

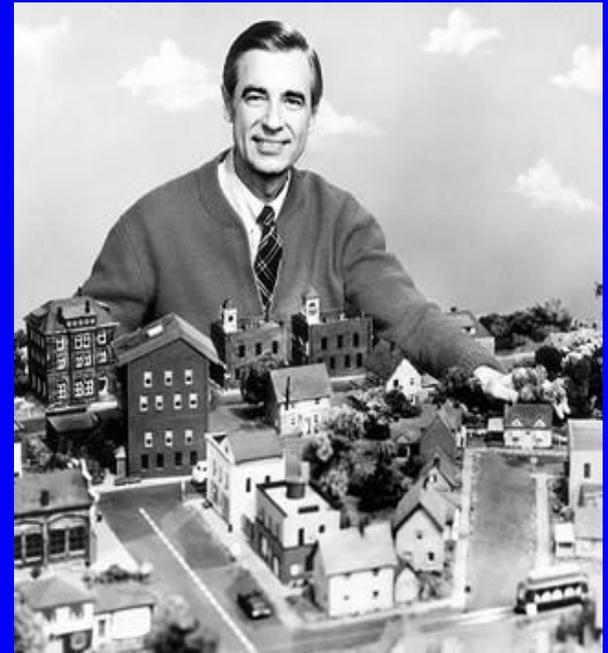
Interaction between team structure and team culture on exhaustion for clinicians (adjusted for covariates)*



* Median split used to define low vs. high team culture.

From Medical Homes to Medical Neighborhoods

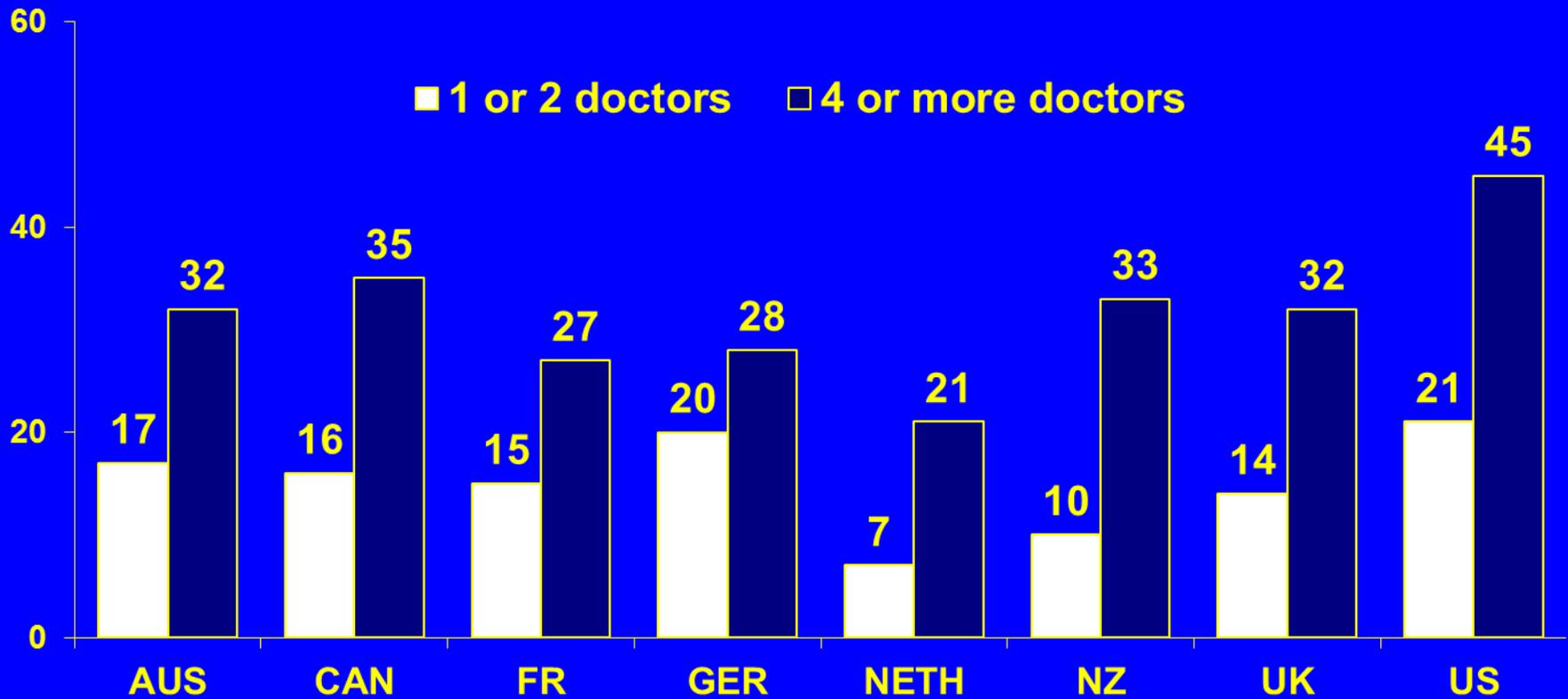
- High performing primary care necessary but not sufficient
- Need the entire system to work together in a coordinated, integrated, patient-centered manner



Care Integration



Coordination Problems with Medical Tests or Records, by Number of Doctors Seen



Data collection: Harris Interactive, Inc.

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Focus Groups on Patient Experiences of Integrated Care

- “Everybody should be on the same page.. in the long run it decreases medical costs to the medical system, because you’re not running duplicate tests”
- “If my doctor sends me to [another doctor] and I say, “did you talk to my doctor?” and they say “no”...So they need to go back to the drawing board, back to start, til you get the same answer from that doctor and that doctor because they’re integrated together.”

*Comprehensiveness – or
“Bringing services into
primary care”*

Colocation of
additional services
into primary care

Capacity building
of primary care
providers

*Coordination – or
“Building relationships
with services outside of
primary care”*

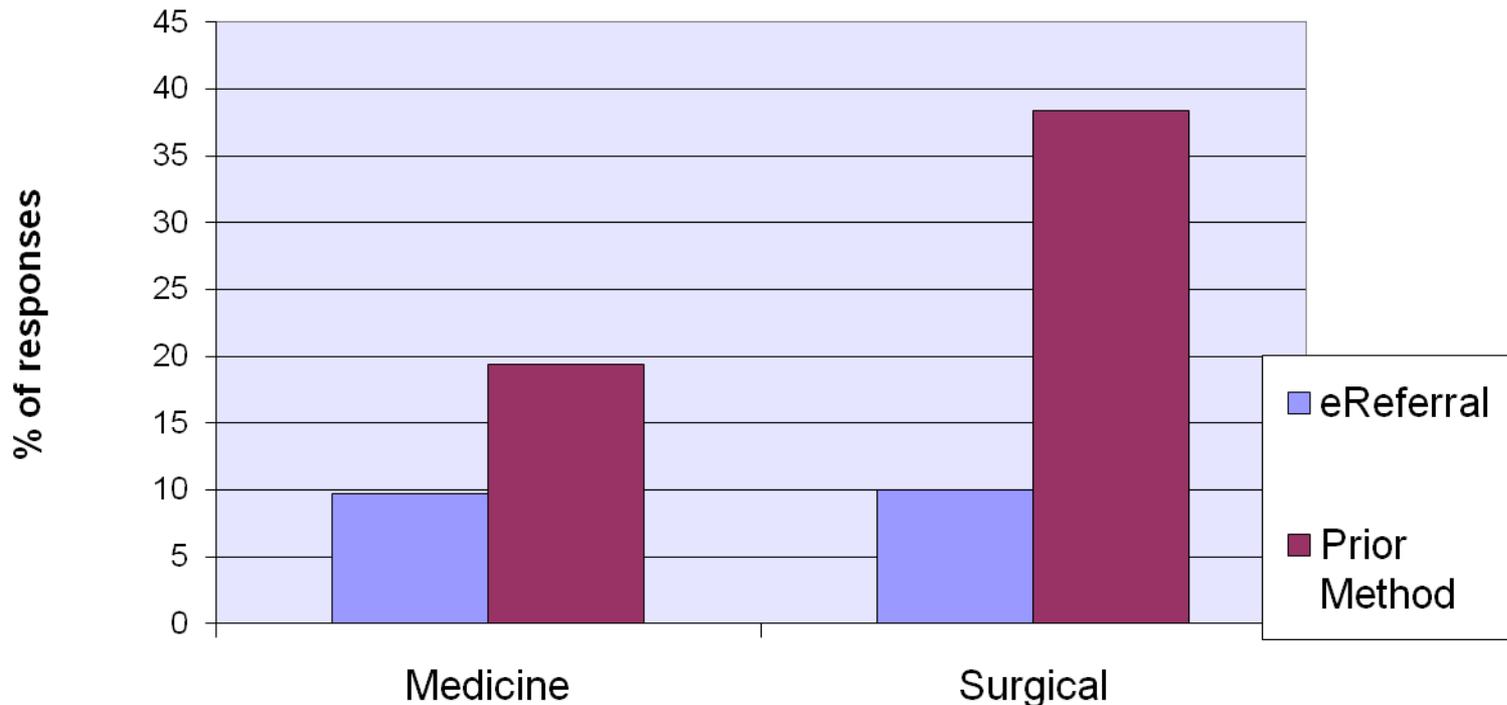
Defining and
developing a
network of service
providers

Improving patient
navigation and
engagement

Improving
communication
and collaboration

SF General Hospital eReferral Evaluation

Proportion of specialists reporting it somewhat/very difficult to identify the consultation/clinical question



Care Transformation Model

Clinical Integration

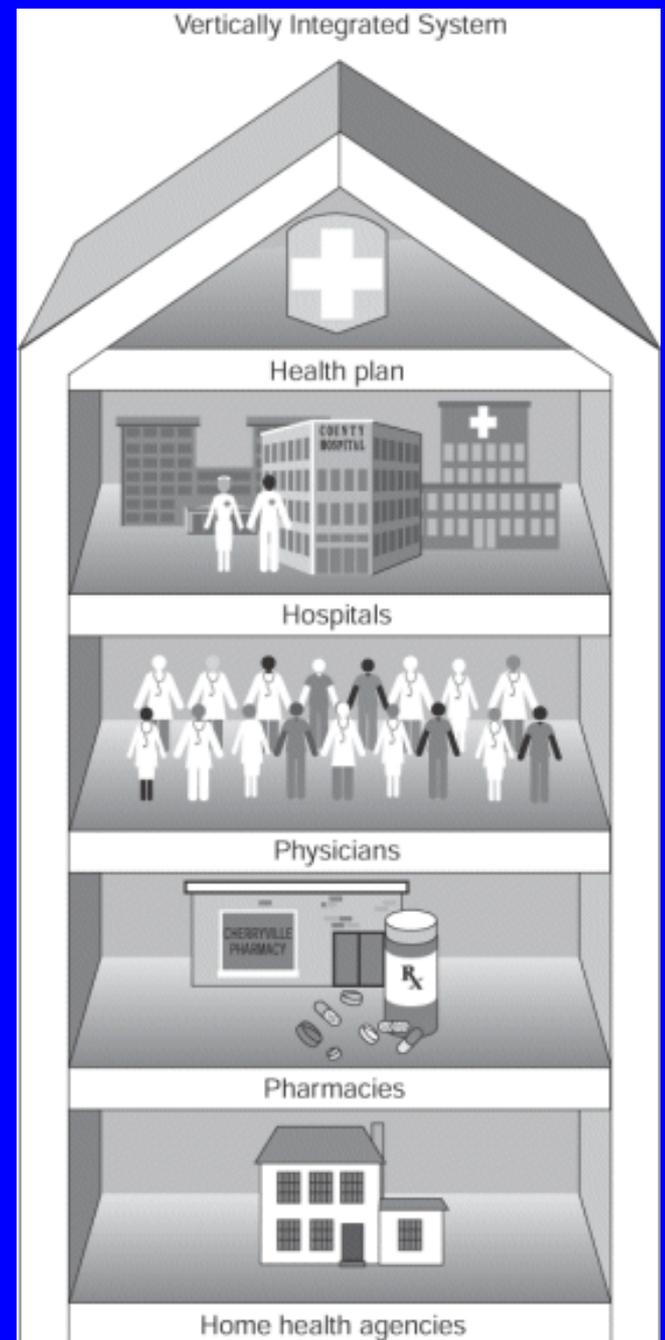
Accountable Care Organization

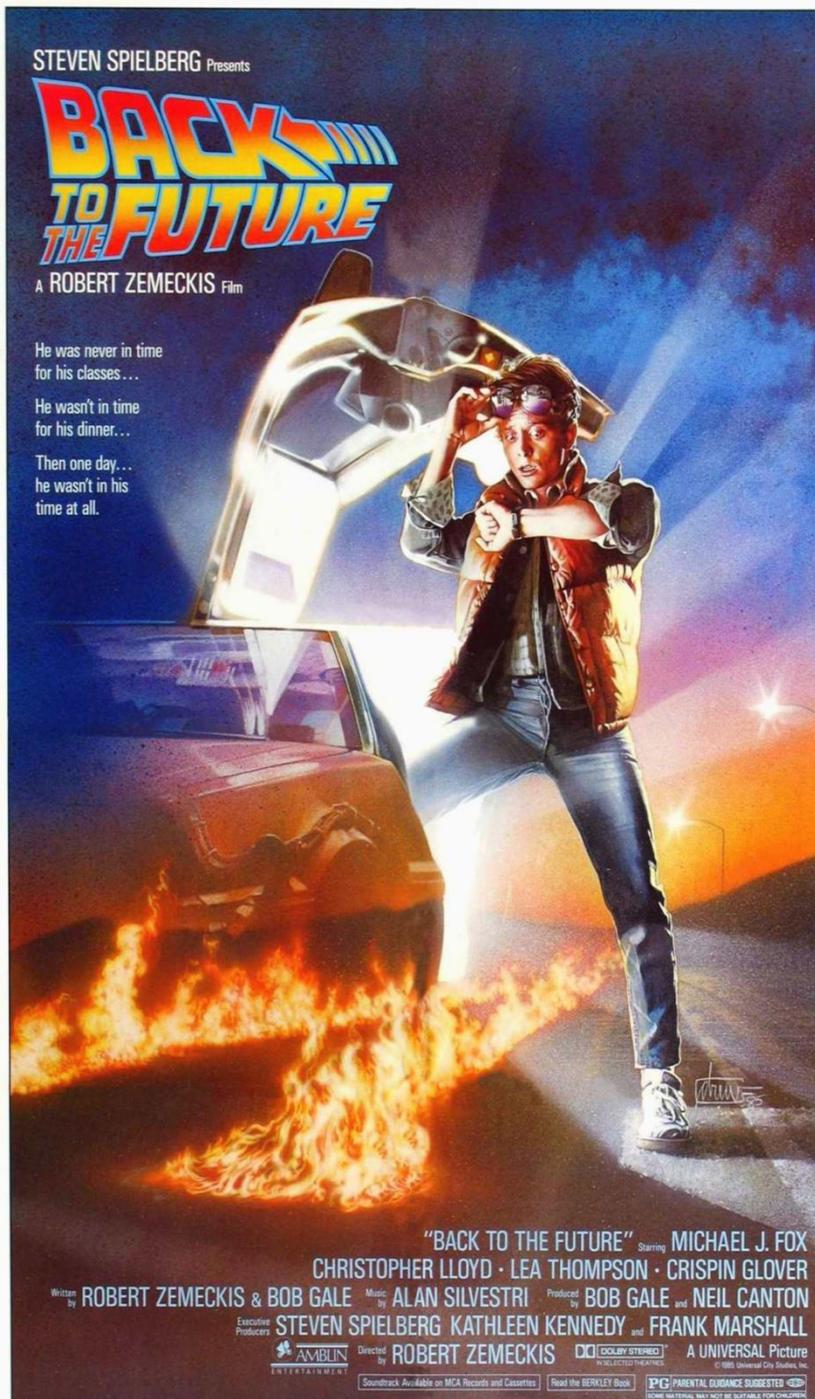
Medical Group
& Enterprise Level Activities

Advanced Primary Care
Under Patient-Centered
Medical Home

Patient & Family

- **Structural Integration**
 - e.g., Kaiser Permanente, Health Partners of Minnesota, Veterans Administration
- **Functional Integration**
 - With or without structural integration
- **Informational Integration**
 - e.g., HIE
- **Financial Integration - Shared Financial Risk**
 - Global risk/full capitation
 - Shared savings
 - Bundled episode payments



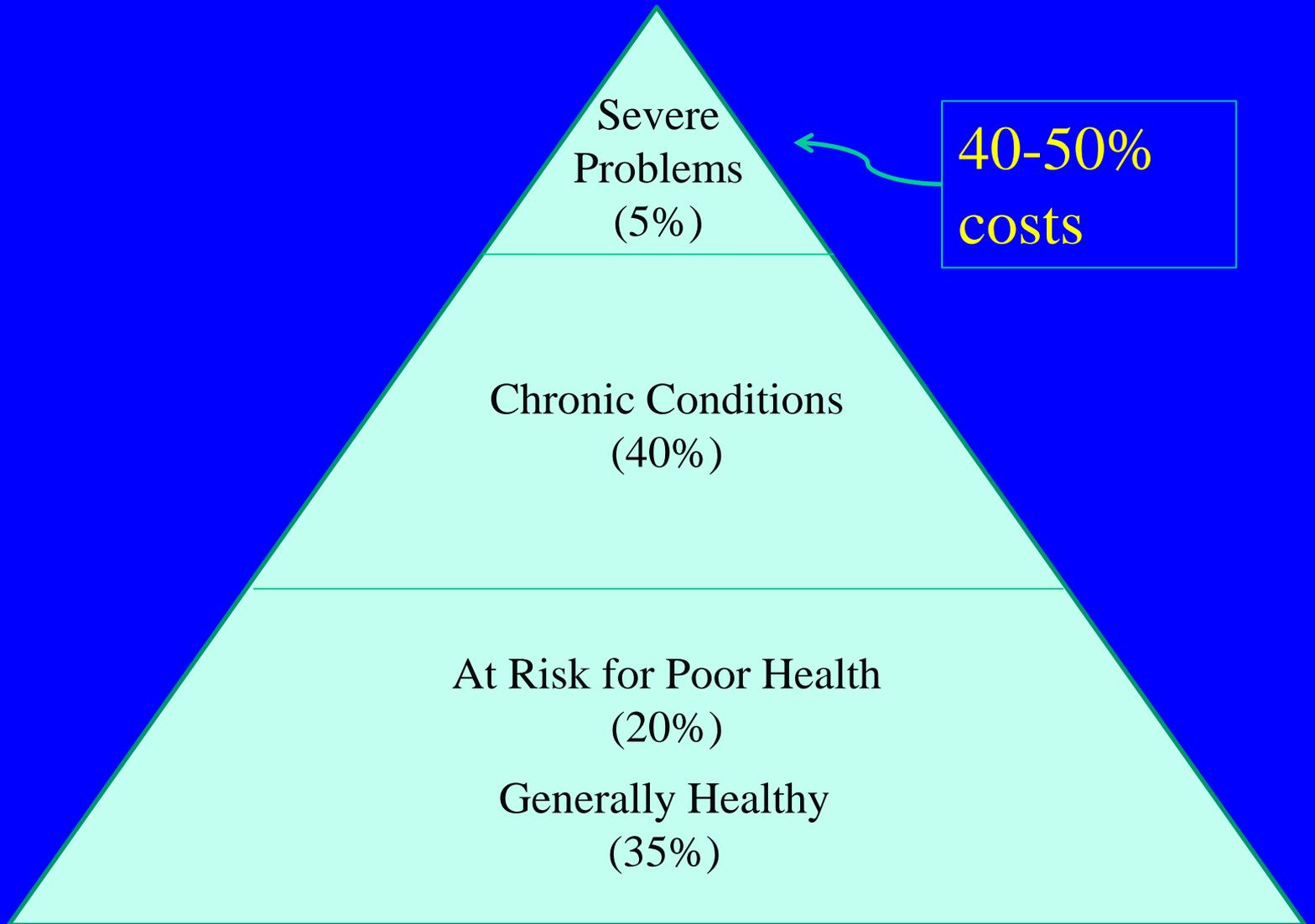


ACOs:
1990s managed care
redux or
transformation to
functionally
integrated, patient-
centered, socially
responsible, primary
care-based medical
homes and
neighborhoods?

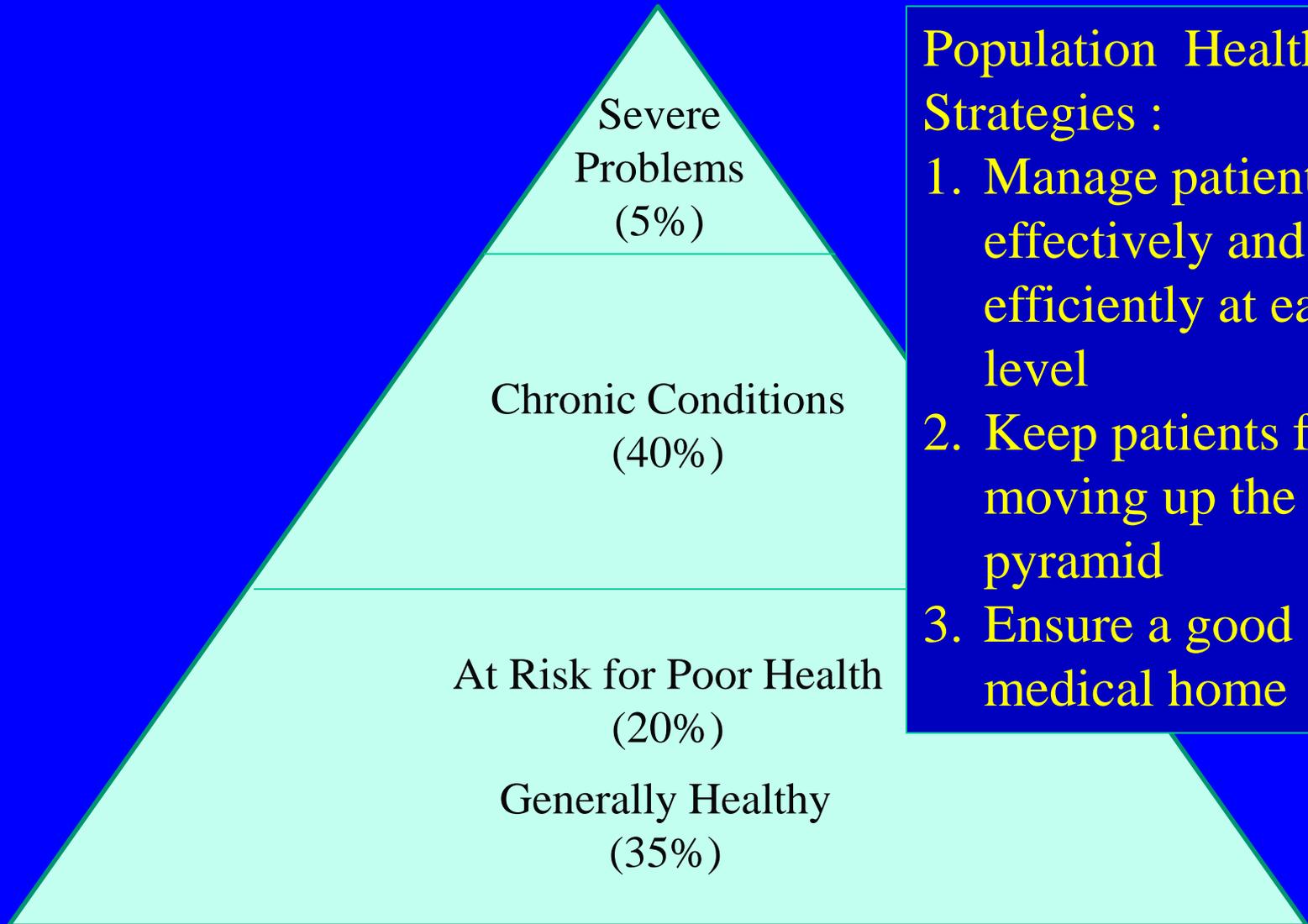
Population Health



Adult Population Risk Distribution



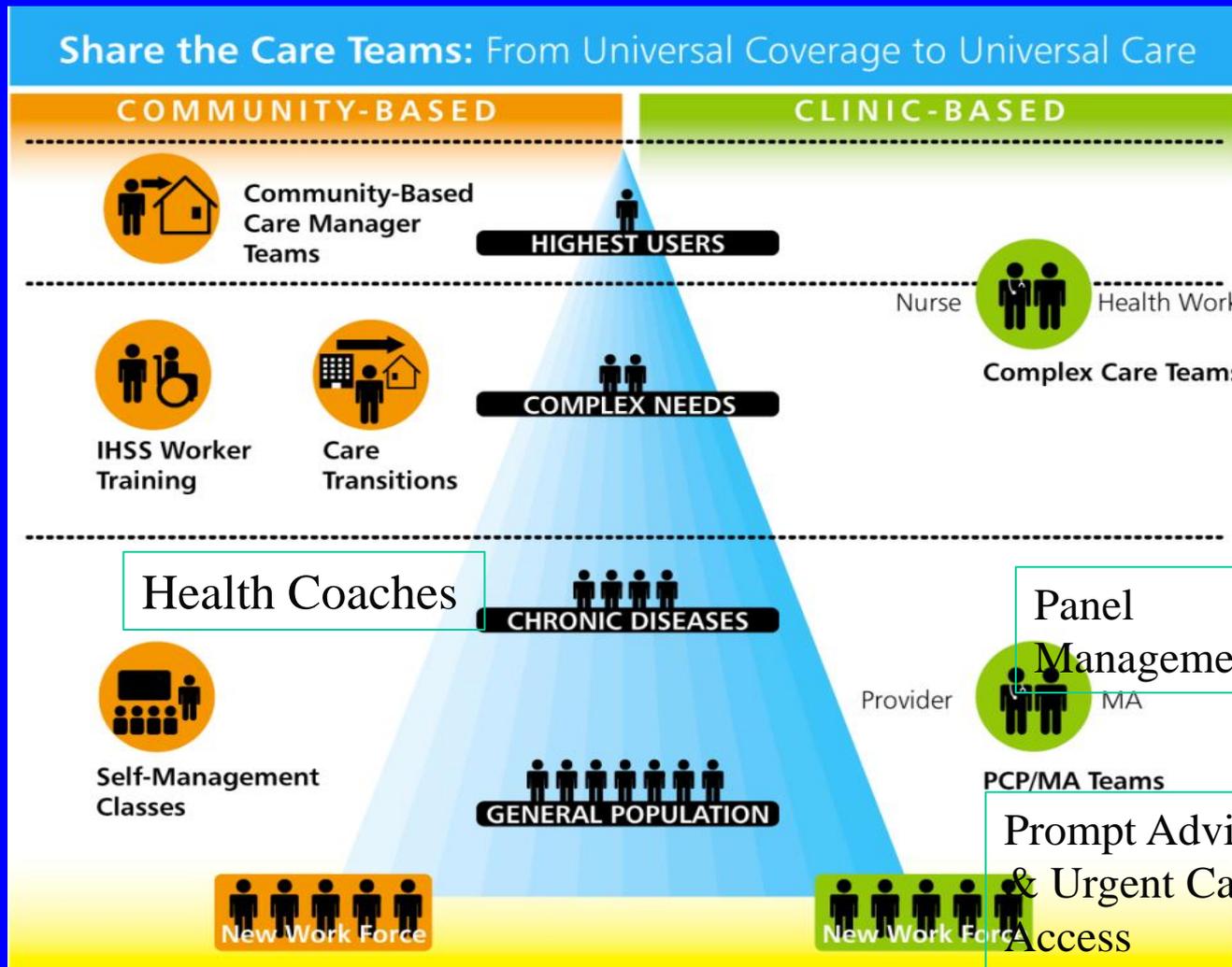
Adult Population Risk Distribution



Population Health Strategies :

1. Manage patients effectively and efficiently at each level
2. Keep patients from moving up the pyramid
3. Ensure a good medical home

Tailor Care Model to Population Strata



Population Health Beyond the Medical Model

Social Determinants

**Fundamental
Conditions**

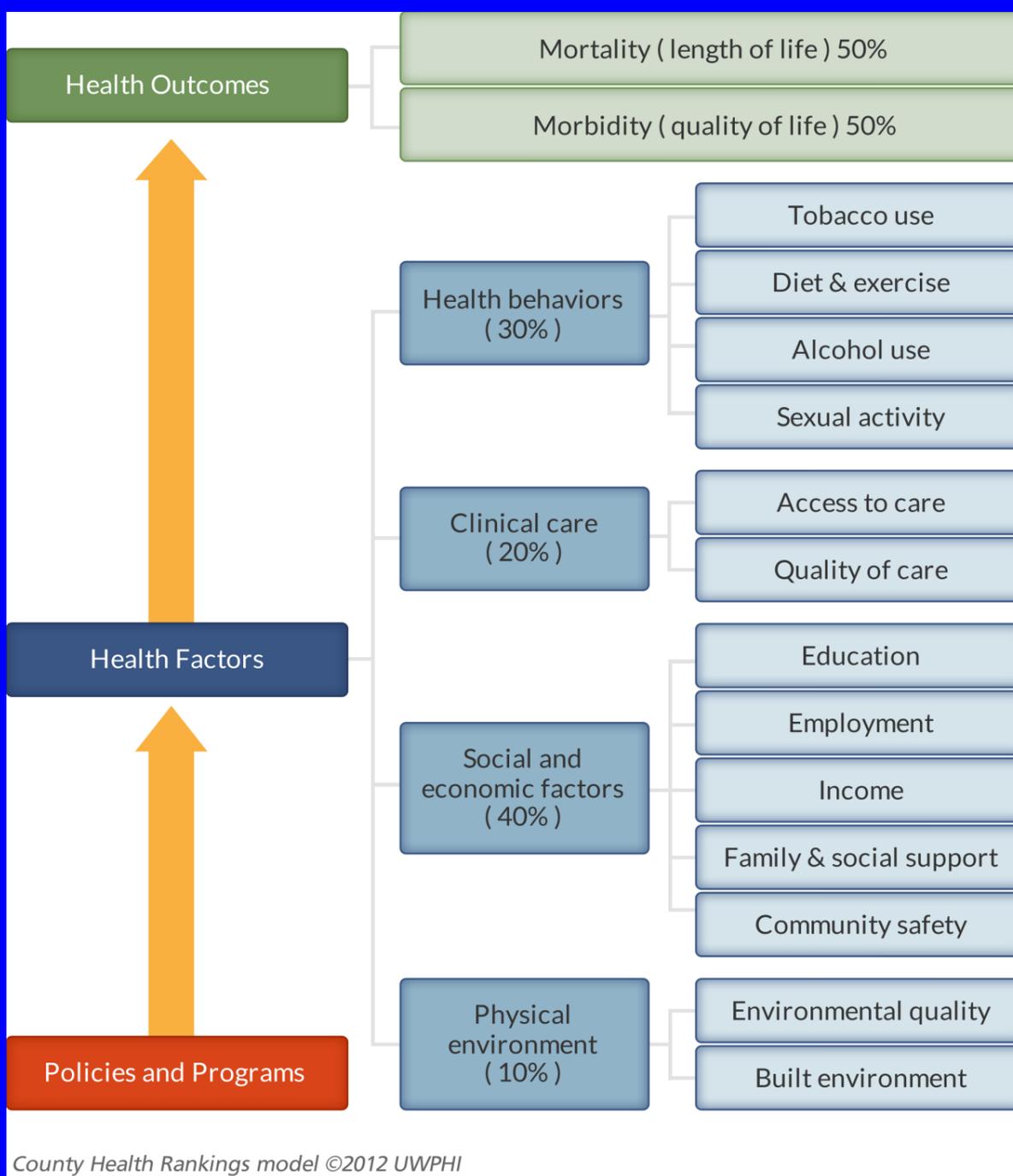
Public Health

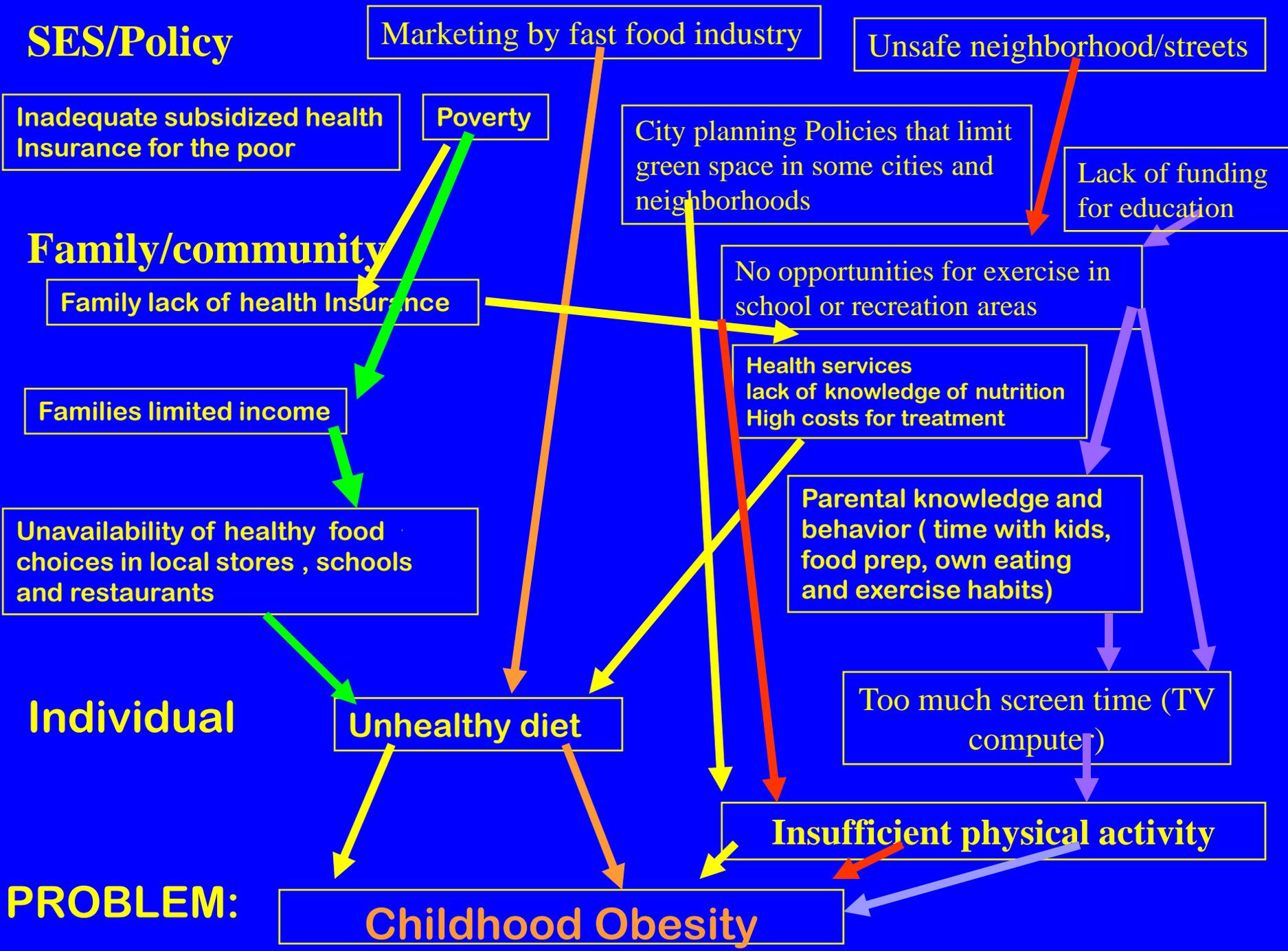
**Behaviors &
Exposures**

Medical Care

**Caring for
Patients**

Population Health Determinants







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Doctors”

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social
determinants of
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WORKING TOGETHER ▾

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HOW CAN THE PRACTICAL PLAYBOOK HELP
WITH YOUR INTEGRATION PROJECT?

<https://practicalplaybook.org/>



**San Francisco
Health
Improvement
Partnership**

What Is SF HIP?



Summary

- Advance primary care with the 10 Building Blocks
- Promote teamwork
- Attend to the quadruple aims
- Create functionally integrated medical neighborhoods
- Think broadly about population health

The Blueprint for Health

