UNIVERSITY OF UTAH
HEALTH CARE

Primary Care 3.0:
Back to the Future?

2013 CLIC Conference
Big Sky, MT

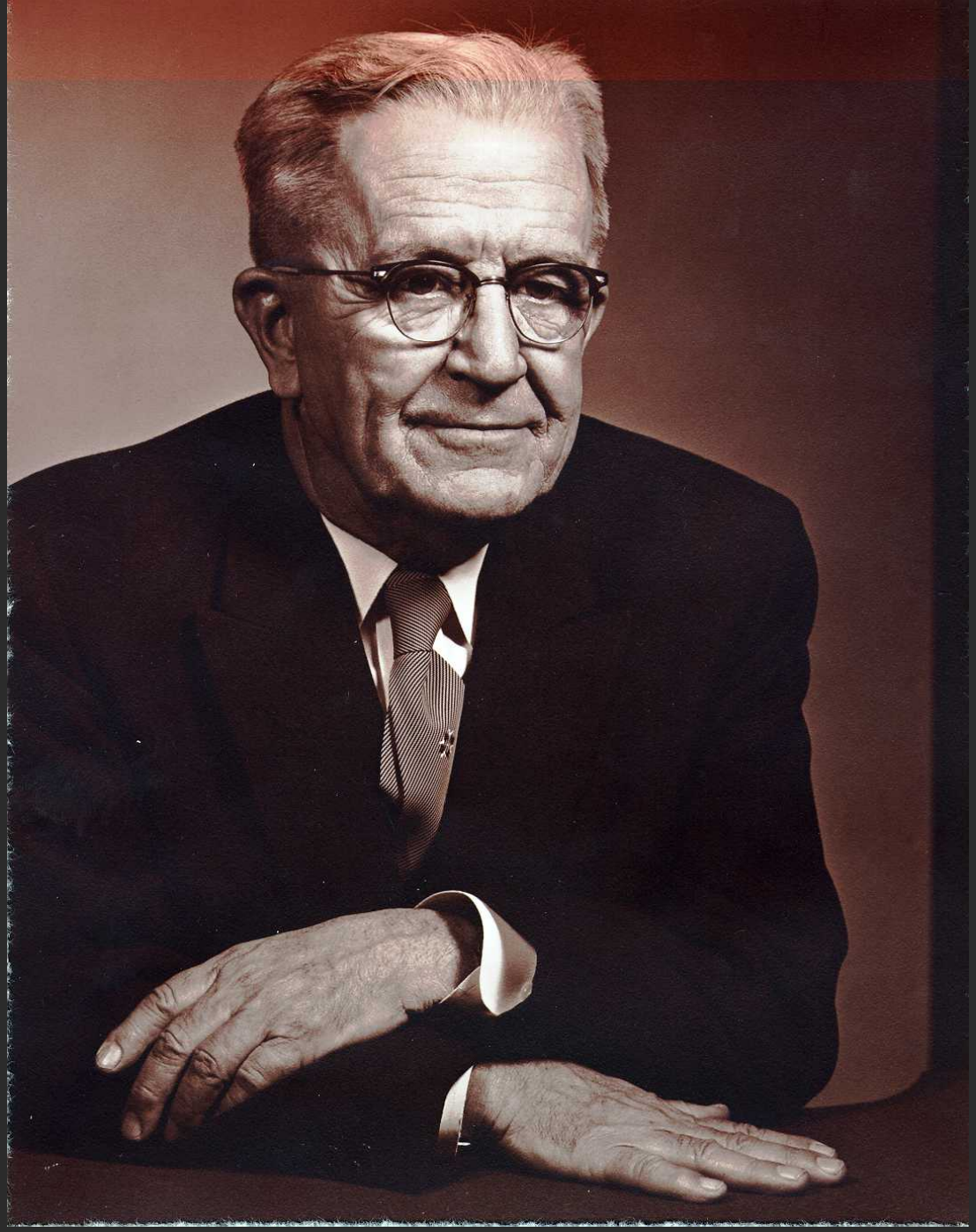
Michael K. Magill, MD

Professor and Chairman
Department of Family and
Preventive Medicine
University of Utah
School of Medicine

Executive Medical Director
University of Utah
Health Plans

UNIVERSITY OF UTAH
HEALTH CARE

Primary Care 1.0:
Solo General Practice



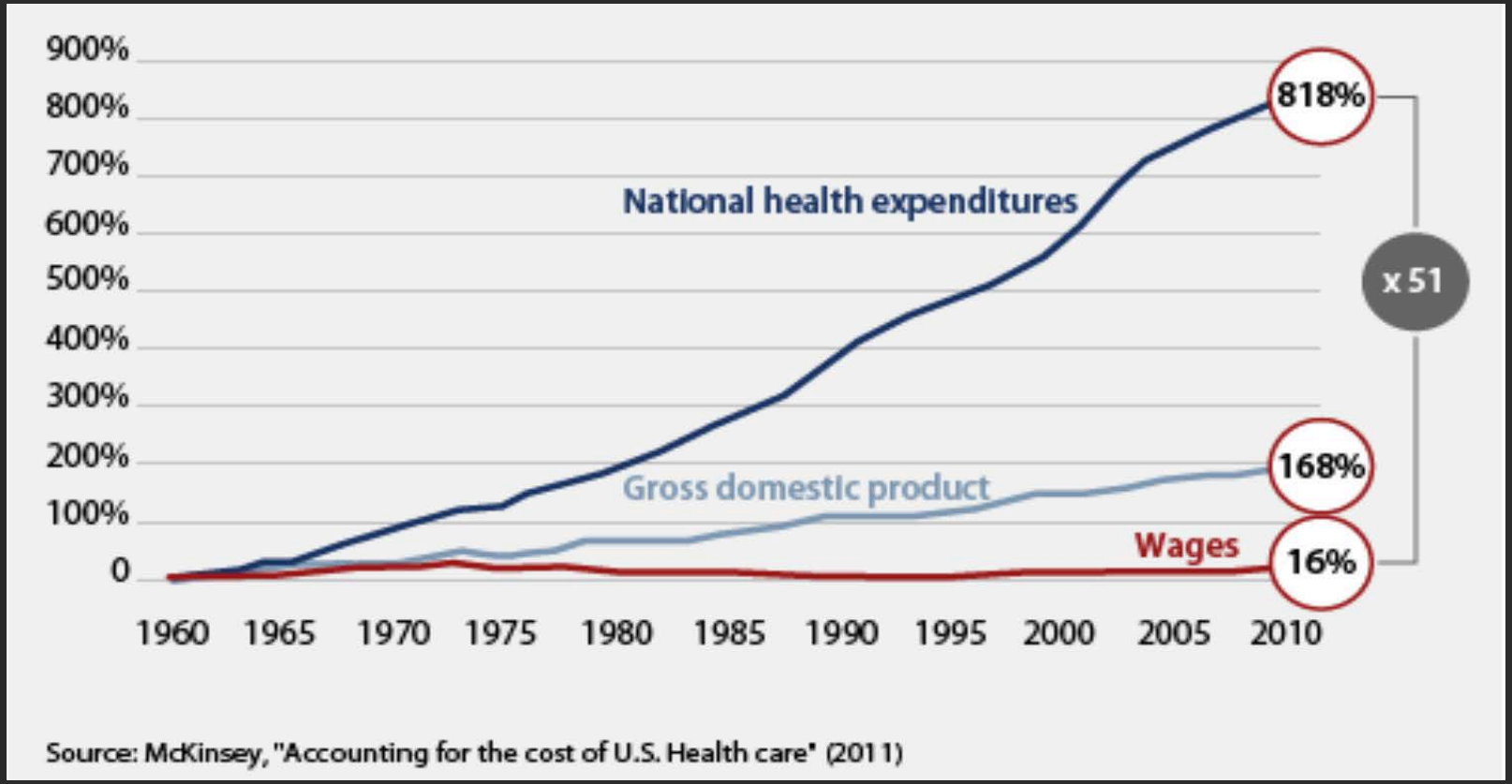
H.A.Moore, MD,
Solo General Practice
Oxford, Ohio
1915-1965


H. A. MOORE, M. D.
SUNNY CREST
OXFORD, OHIO
PHONE 33
HOURS - EVENINGS AND BY APPOINTMENT
DIRECTIONS INSIDE

Why redesign health care?

Crisis

The cost of health care in the past 50 years has risen more than 800%, almost 5x the rise in the gross domestic product and over 50x the increase in wages for the average American.



Goal of Redesign: The Triple Aim

The IHI *Triple*Aim

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

- Better health
- Better care
- Lower cost

Business Model

Revenue Enhancement

Cost Reduction

Achieving the Triple Aim:

"The two major problems in U.S. health care are…

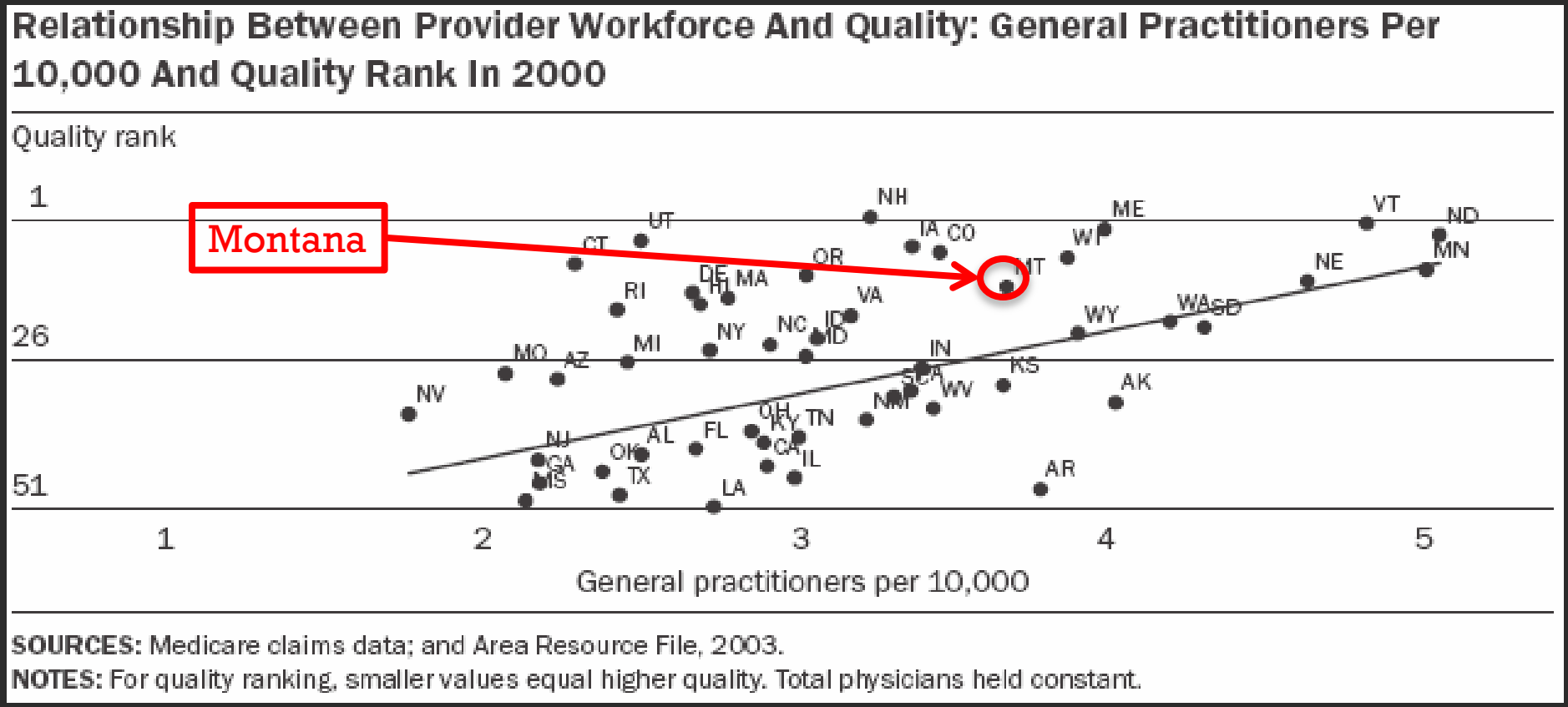
- the way we deliver primary care, and
- the way primary care is financed"

"Primary care is the only natural locus of control of health care quality and costs"

Paul Grundy MD, MPH, FACOEM, FACPM
Director of Healthcare, Technology and Strategic Initiatives, IBM
President, Patient Centered Primary Care Collaborative
Adjunct Professor, Family and Preventive Medicine,
University of Utah School of Medicine

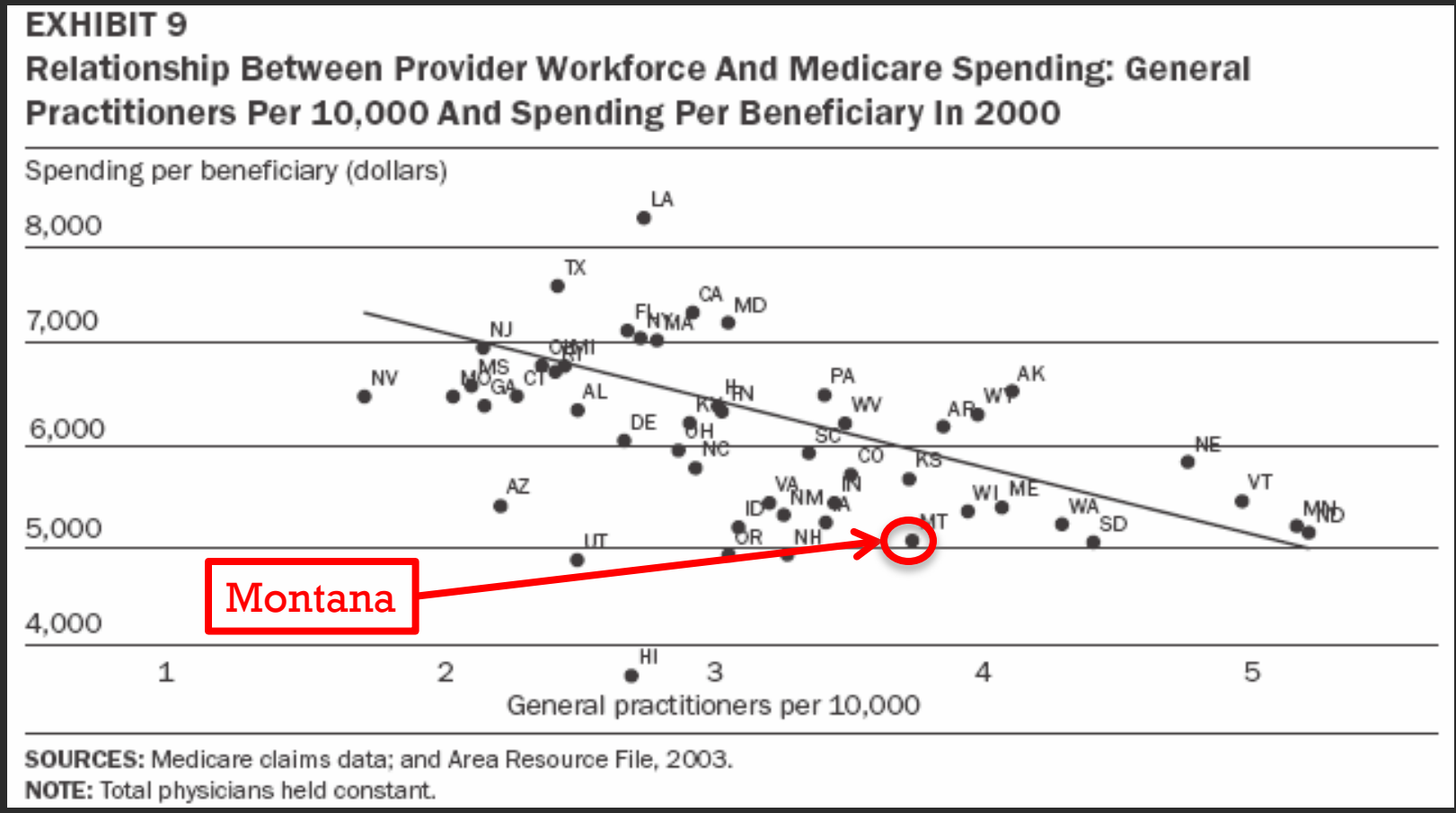
http://www.aafp.org/online/en/home/publications/news/news-now/opinion/20080207bren-grundy.mem.html accessed 5/15/08

Primary Care = Higher Quality



Baicker, Health Affairs 2004

Primary Care = Lower Cost

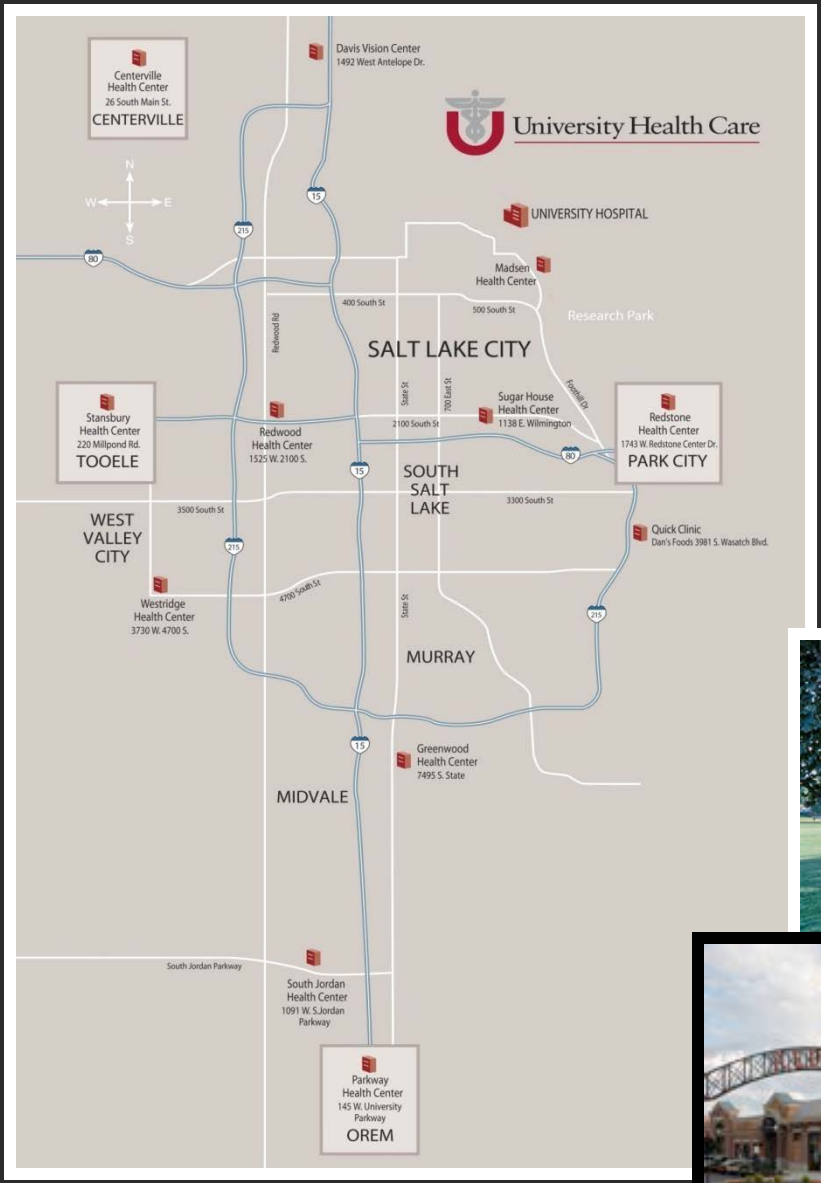


Baicker, Health Affairs 2004

UNIVERSITY OF UTAH
HEALTH CARE

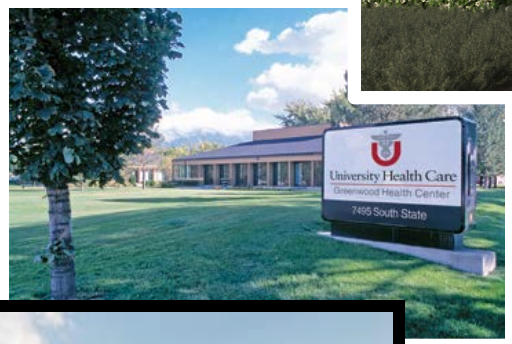
Primary Care 2.0:
Patient Centered Medical Home

10 Community Clinics



Visits: 320,000

Active patients: 100,000



Definition: Medical Home

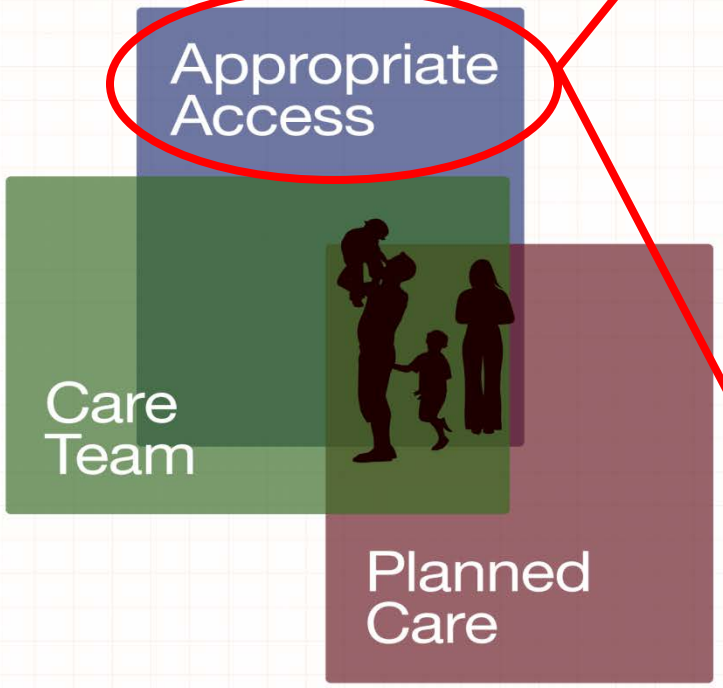
- Comprehensive
- Patient-Centered
- Coordinated
- Continuous
- Accessible
- Quality and Safety
- Others: IT, Workforce, Payment

http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2

care BY design

University Health Care
Community Clinics

care BY design

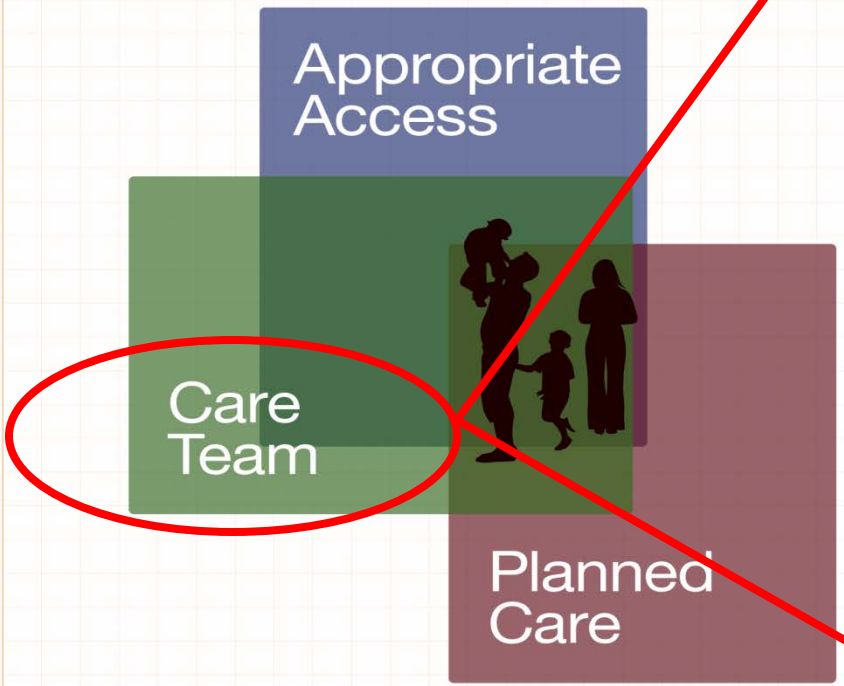


University Health Care
Community Clinics

Appropriate Access

- Patient centered care requires access
- Understand acute and chronic care demand
- Balance supply and demand
- Standard appointment types
- Contingency planning
- Balance capacity in the team

care BY design

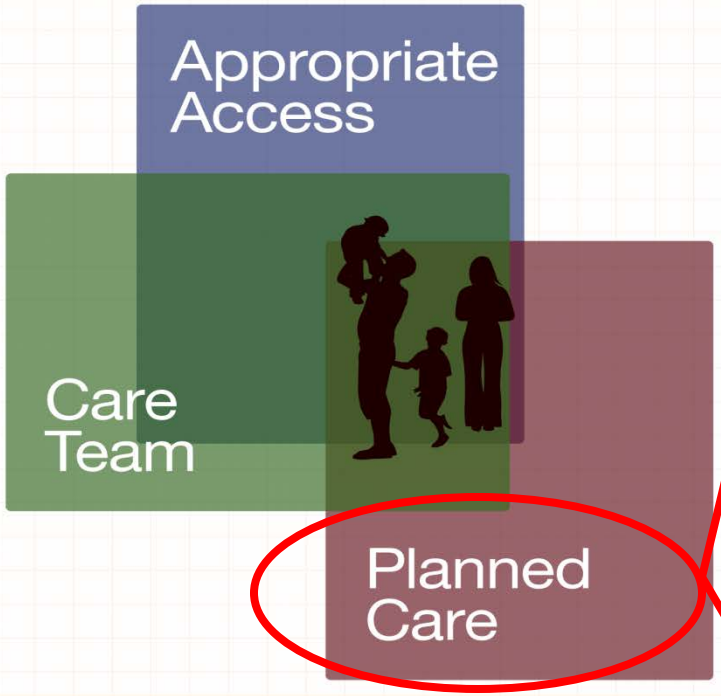


University Health Care
Community Clinics

Care Team

- Patient is the center of the team
- Team knows the patient's care plan
- Evidence-based strategies for care
- Maximize skills of team members
- Open and real time communication

care BY design

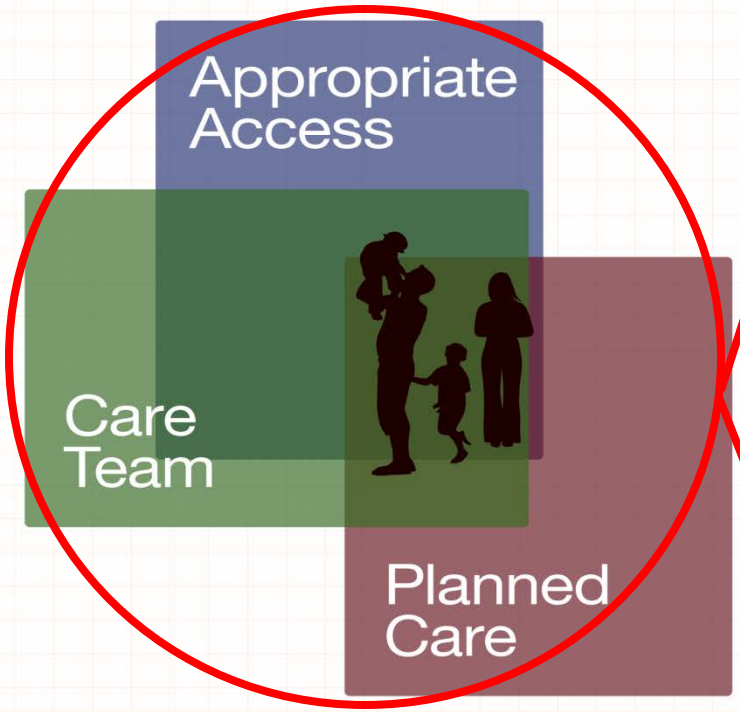


University Health Care
Community Clinics

Planned Care

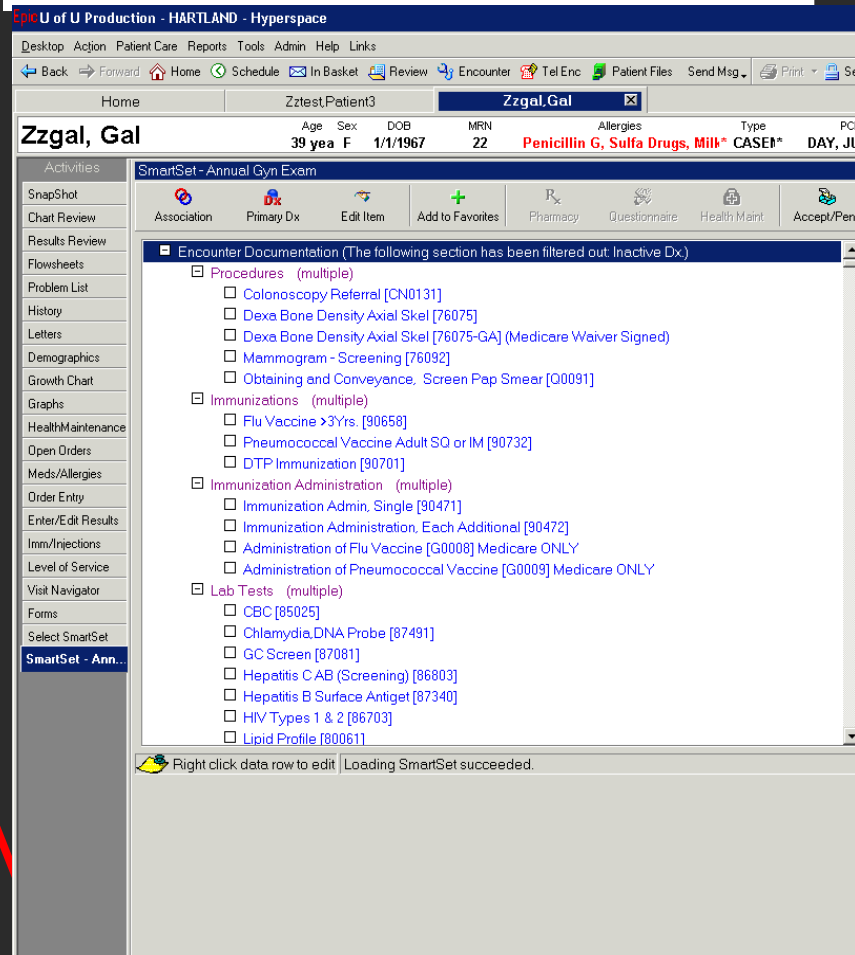
- A plan—in writing—for every patient
- Evidence-based care plans
- Mutual goal setting
- EMR tools
- Pre-visit planning eliminates waste

care BY design



University Health Care
Community Clinics

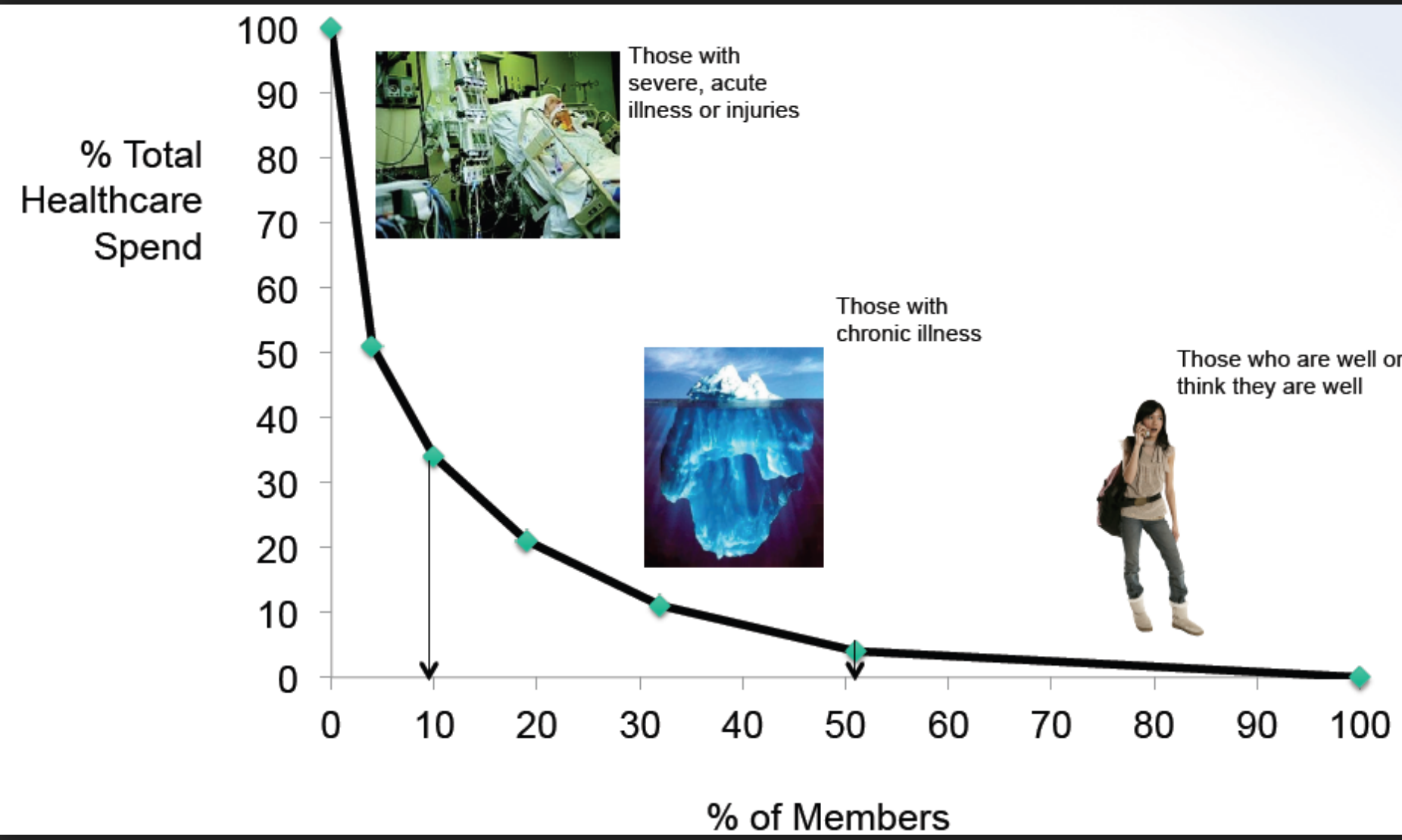
- Electronic Medical Record



UNIVERSITY OF UTAH
HEALTH CARE

Primary Care 3.0:
Mass Customization to Create Healing Relationships

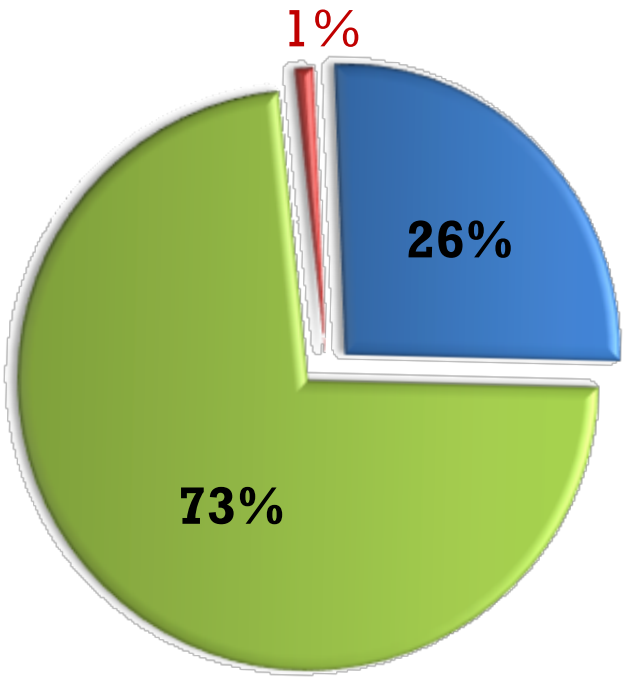
Different strategies for healthcare spending



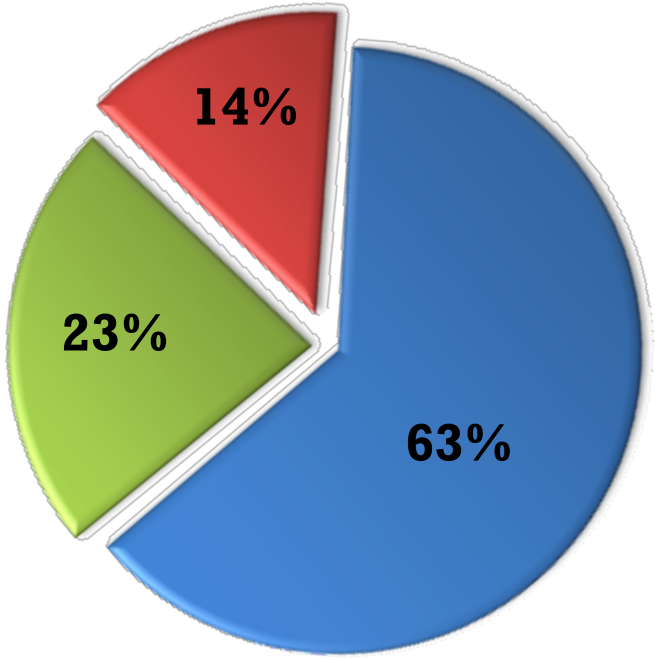
Source: Wellspan Health

Spend Segments

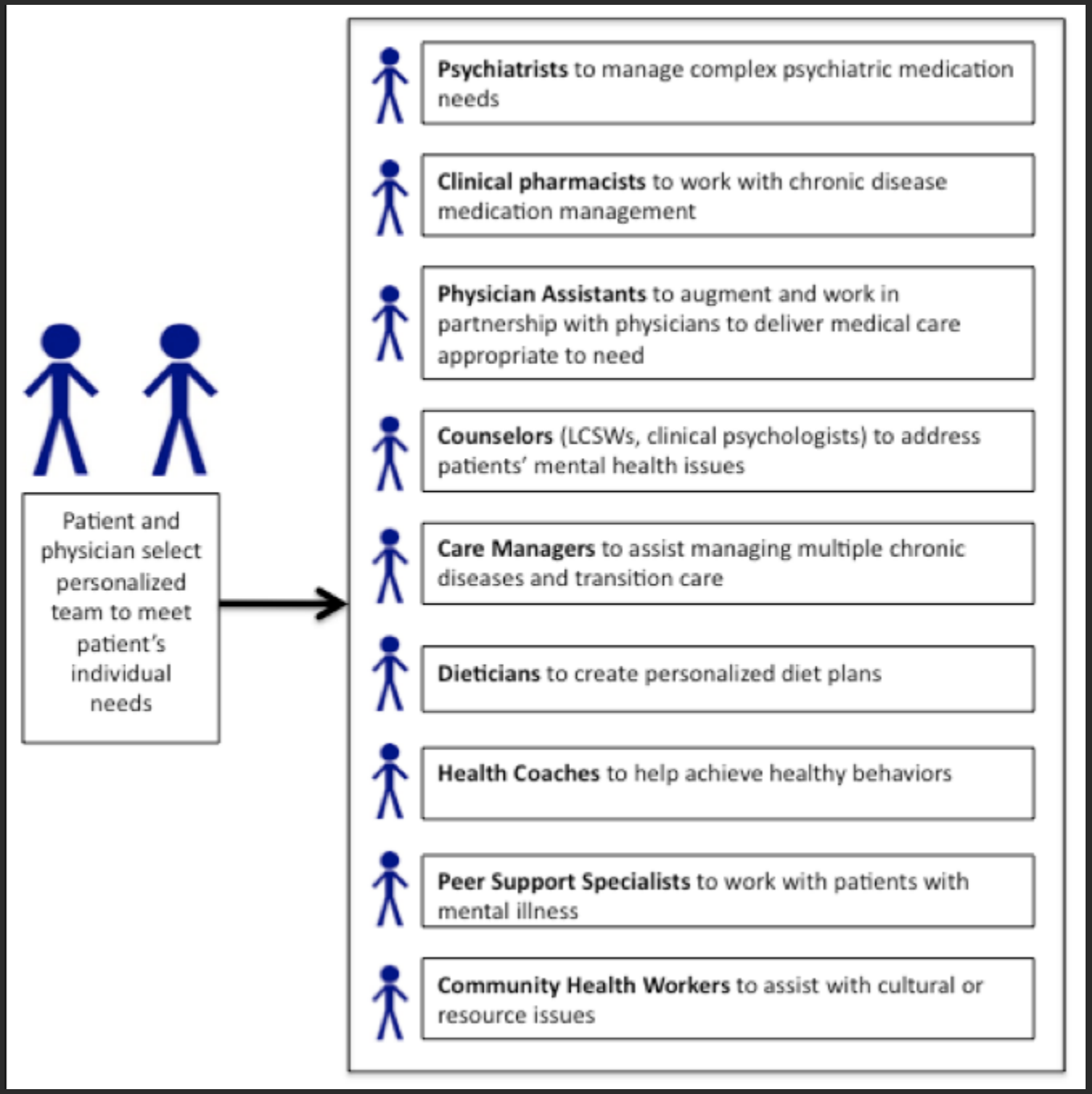
Members



Costs



- High risk - Acute
- Chronic condition
- Healthy today



Team for Advanced Primary Care

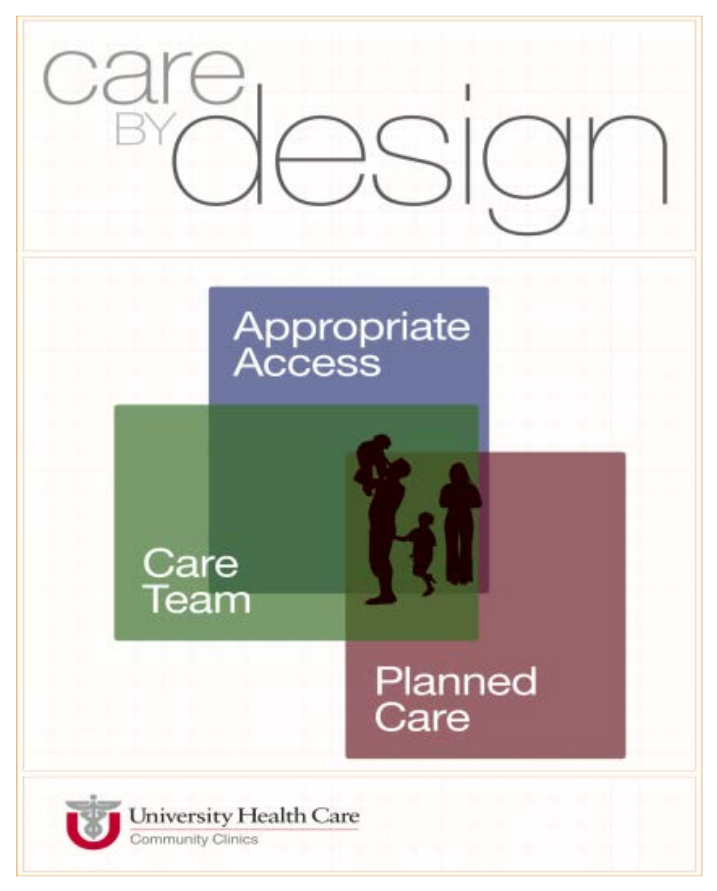
The Health Center

"We are your doctor"

John D. Matthew, MD, FACP
The Health Center
Plainfield, VT

Dartmouth COOP Project
2012

Care by Design™



- Appropriate Access – 2003
  - Balance visit supply and demand
  - Standardized schedules
- Care Team – 2004
  - Expanded MA role
  - Providers and MAs working in teams
  - EMR tools (BPAs, Xfiles)
- Planned Care – 2006
  - Protocols, order sets
  - Pre-visit planning, labs
  - Registries

Extending the Medical Home into the Medical Neighborhood

- Appropriate Access
- Care Teams
- Planned Care

- Employed by CC
- Embedded w/in University Hospital

Care Management

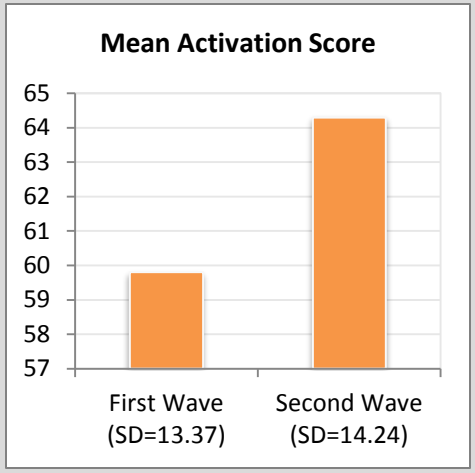
Transition Navigator

- Care Manager
- Behavior change & Self-mgmt coaching
- Care Coordination
- Transitions Management

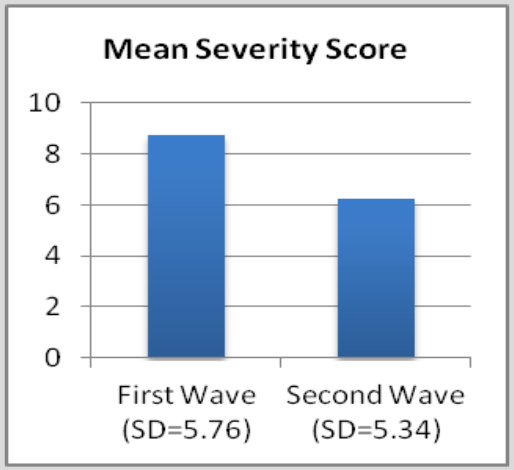
http://www.youtube.com/watch?v=HClzQLCBRz4

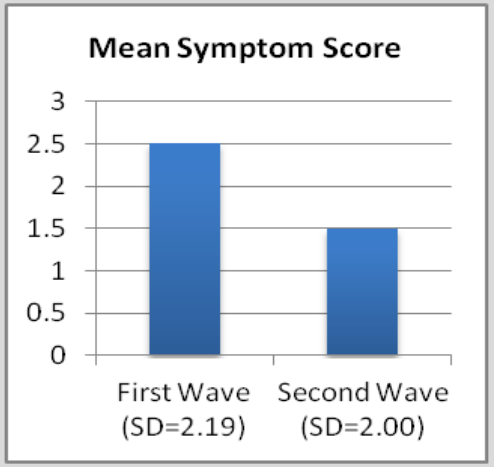
Patient Reported Outcomes:

Change between 1st & 2nd administration

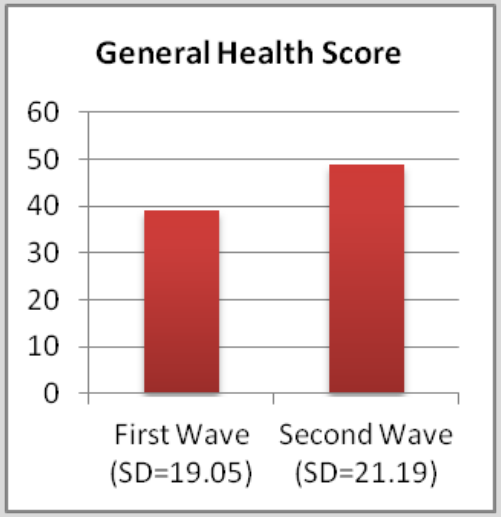


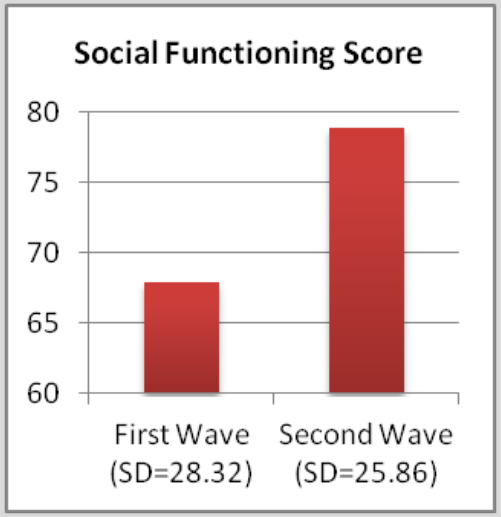
PAM (t-test p=.057)

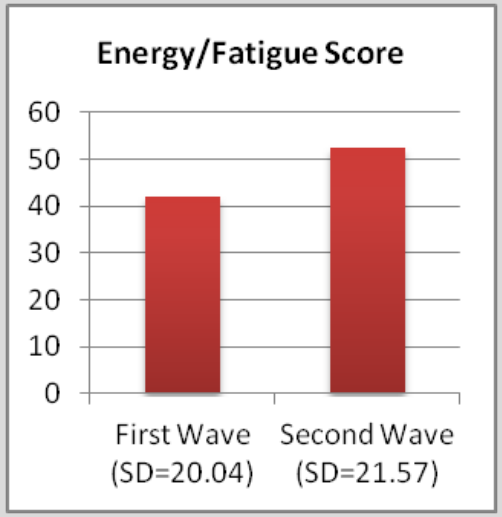




PHQ9 (t-test p<0.01)

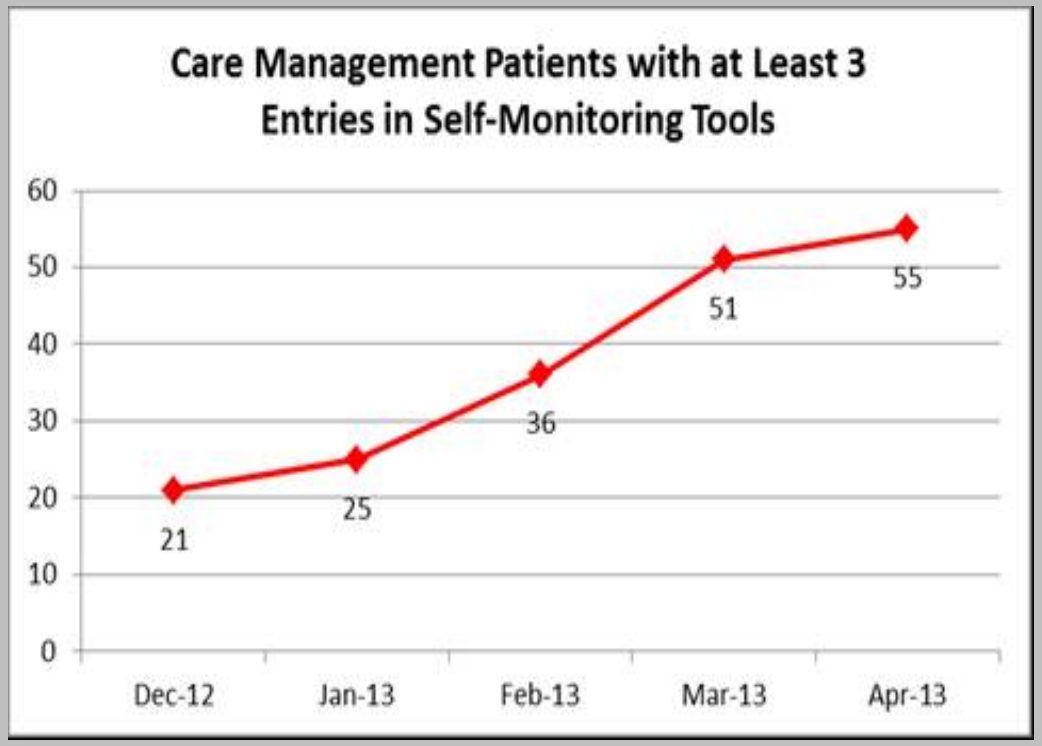






RAND 36 (t-test p<0.01)

Self-Monitoring Tools



Self Monitoring Tools: weight, BP, glucose, exercise

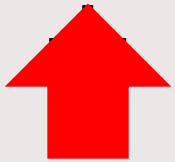
Patient Experience

with PCMH Domains

CBD Element	PCMH Domain	Question Items	Overall Mean
Appropriate Access	Access	5	3.25
Care Teams	Communication	6	3.74
	Whole person orientation	3	4.86
	Care Coordination	3	3.53
	Shared decision-making	3	3.33
Planned Care	Comprehensive care	2	1.50
	Continuity of Care	2	1.54
	Self-management support	2	1.94

Patient Experience

and Level of Implementation of CBD

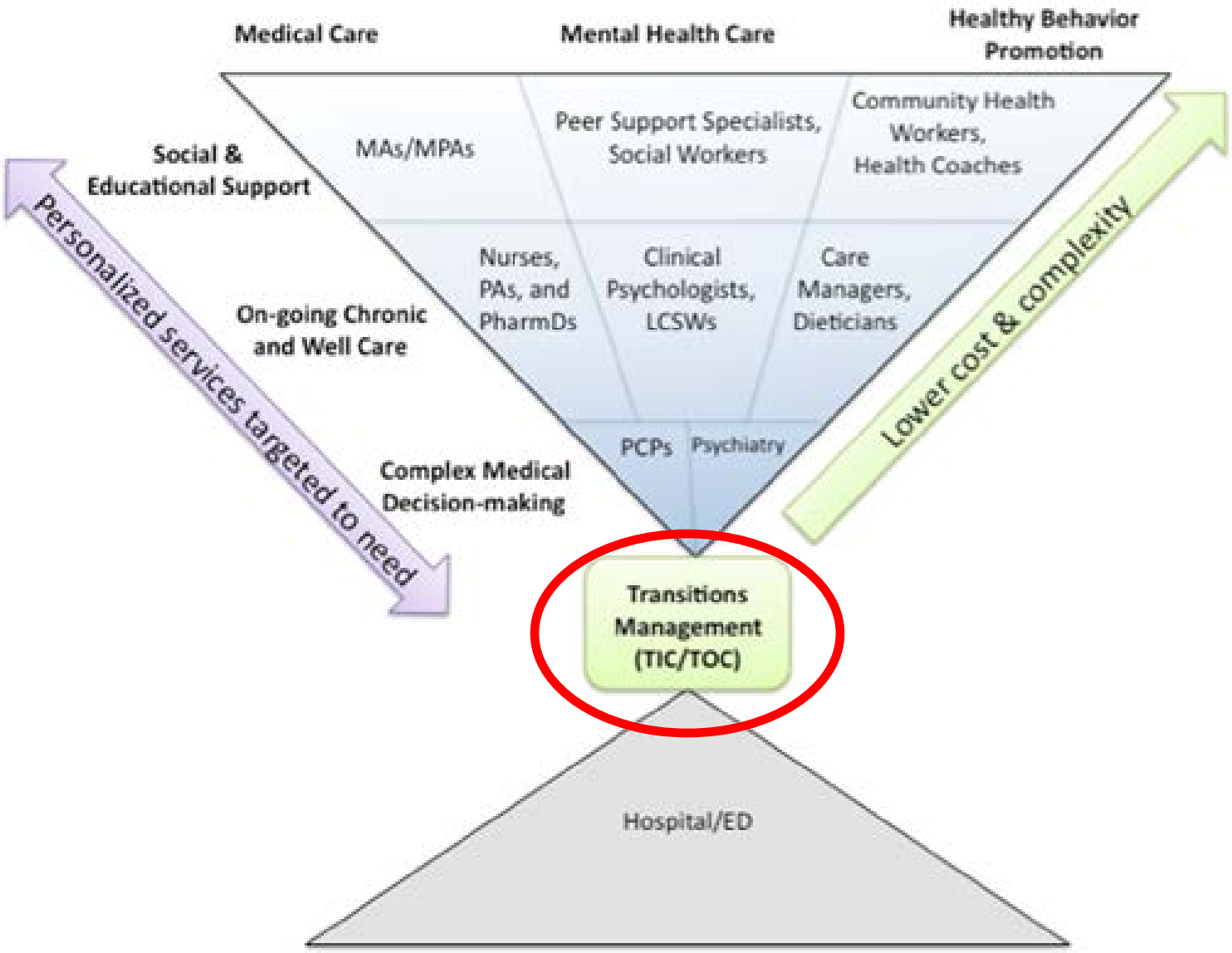
CBD Element	Patient Experience		
	Access to Care	Communication	Comprehensiveness of Care
Appropriate Access		NS	
Care Team	NS		

- Extent of implementation is not related to all domains of experience
- Transformation may not be readily visible to patients (“behind the scenes”)

Continuity of Care Reduces Cost

- Intervention: CBD through 2009
- Patients: Nonelderly
  Diabetes, Coronary Artery Disease, Heart Failure
- Continuity (by site) = $\frac{\text{Visits to One Community Clinic}}{\text{Total Visits}}$
- ↑ Continuity 10% ⟶ ↓ Charges $350/year
- Conclusion: PCMH may control cost, especially for patients with chronic conditions

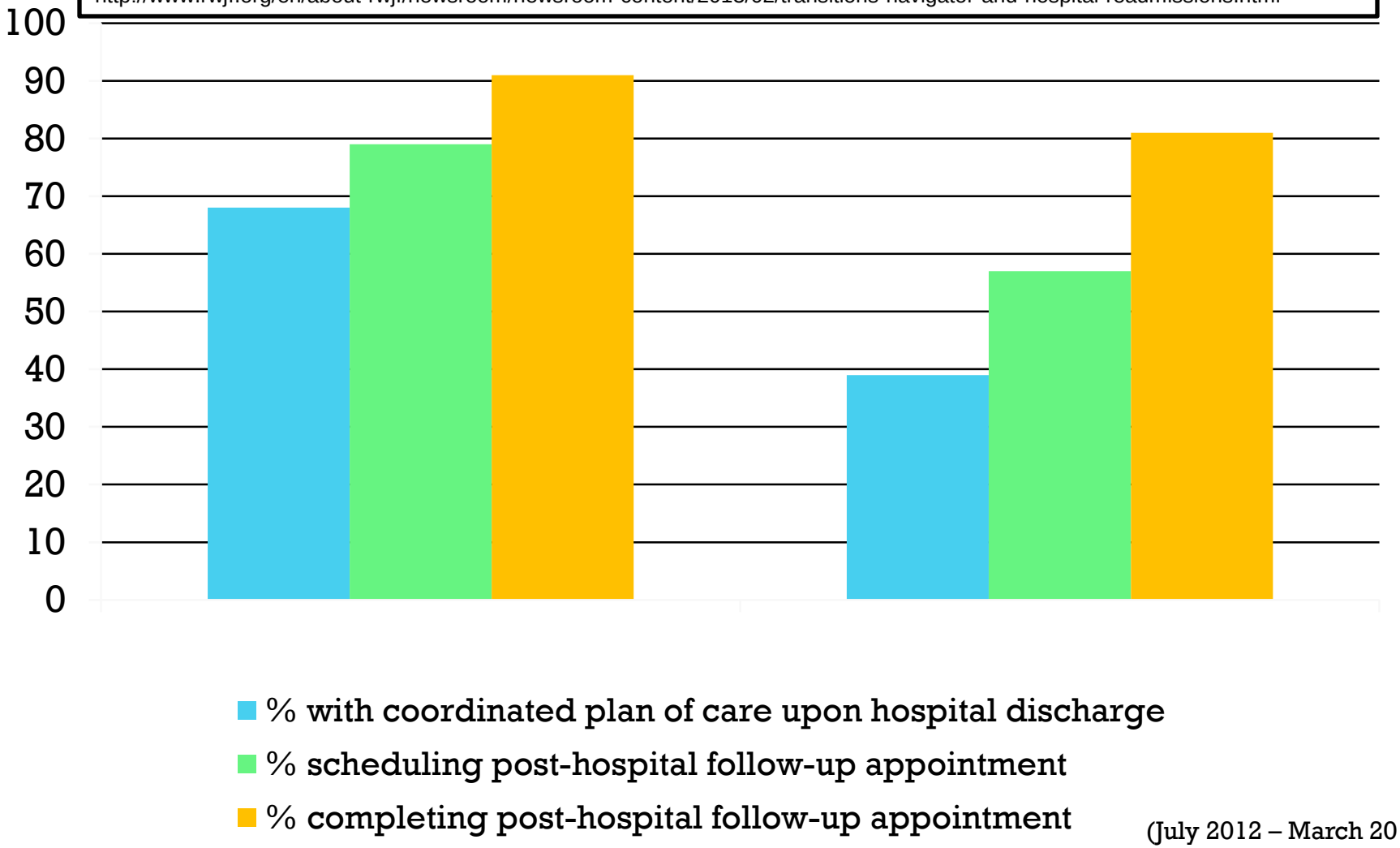
"Primary Care 3.0"



Impact of TN on Care Coordination

23% preliminary, unadjusted relative reduction in 30-day readmissions among patients receiving transitions navigator services.

http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2013/02/transitions-navigator-and-hospital-readmissions.html



(July 2012 – March 2013)

Overall Conclusions

- **Positive patient experience in PCMH domains**
  - Access
  - Communication
  - Care coordination
- **Transitions navigation** as part of PCMH improves
  - Primary care follow-up
  - Readmission rates
- **Continuity by site** was associated with **lower total health care costs** in patients with multiple chronic diseases

Essential Ingredients Primary Care 1.0 *and* 3.0

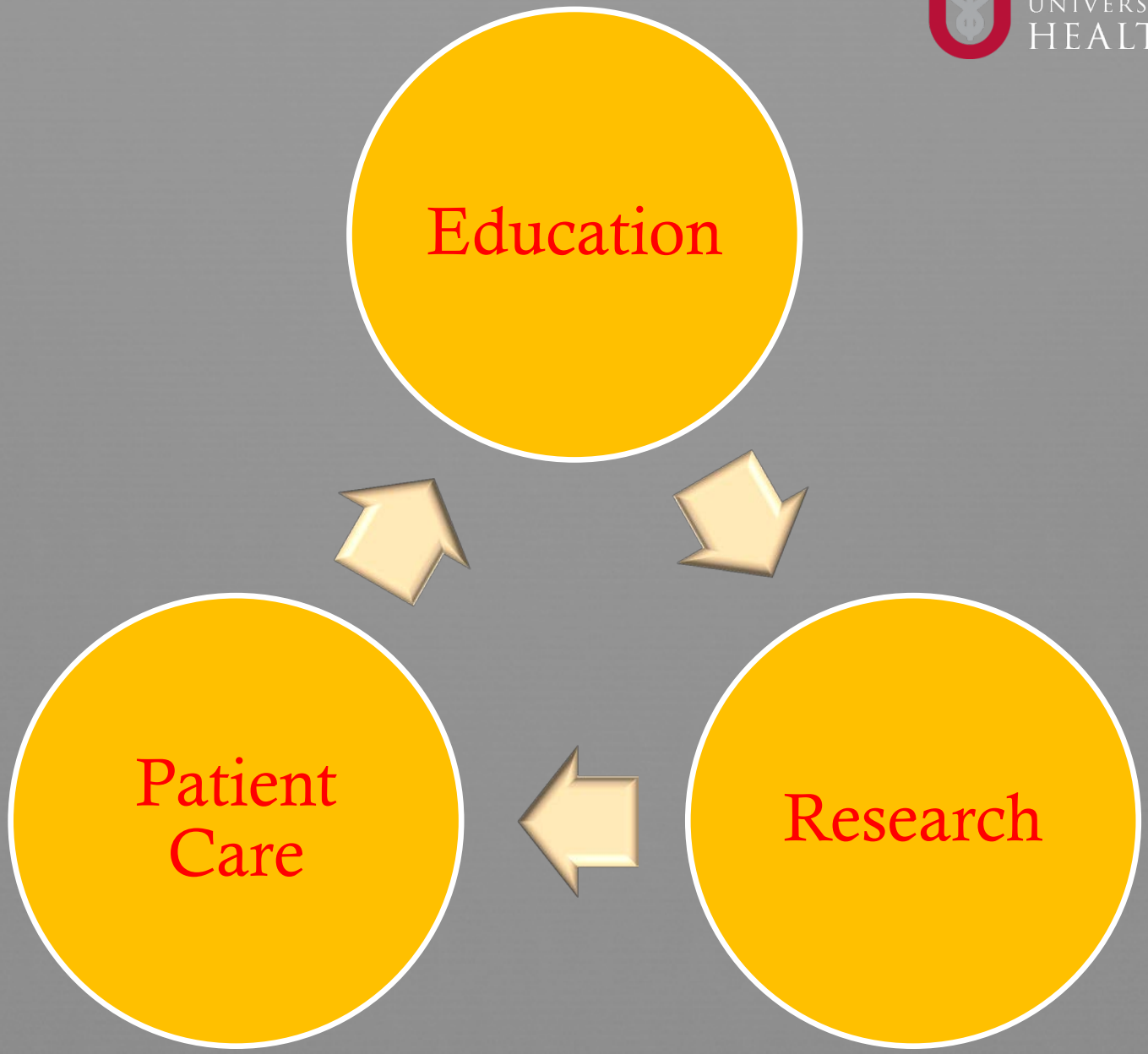
- Continuity
- Comprehensiveness
- Coordination
- Relationships
  - Patient – provider
  - Team

UNIVERSITY OF UTAH
HEALTH CARE

In Search of…
Primary Care 3.0

- Medical Education
- Health System Change

UNIVERSITY OF UTAH
HEALTH CARE



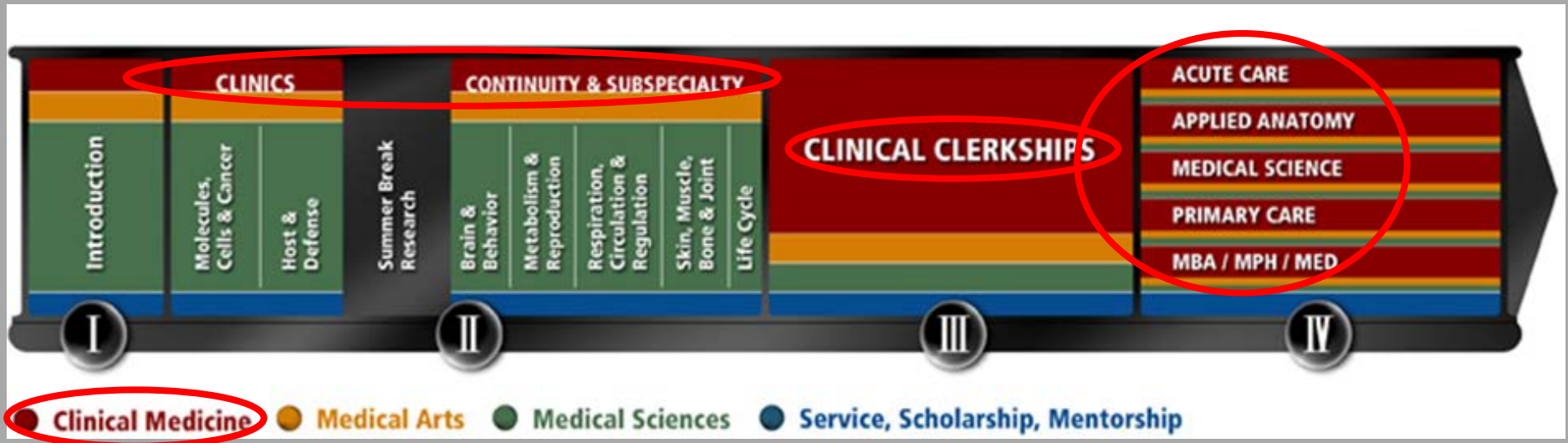
UNIVERSITY OF UTAH HEALTH CARE

- **Practice what we teach**
- **Teach what we practice**
- **Research how to do better**

J. Lloyd Michener, MD
AAMC Annual Meeting
November 7, 2009

UNIVERSITY OF UTAH HEALTH CARE

Curriculum:
University of Utah School of Medicine



Clinics: Continuity & Subspecialty

Clinical Clerkships:
Medicine
Surgery
Pediatrics
Obstetrics/Gynecology
Family Medicine

Acute Care
Applied Anatomy
Medical Science
Primary Care
MPH/MBA/MEd

UNIVERSITY OF UTAH HEALTH CARE

Residency

- Train in PCMH
- Quality Improvement

Improving patient satisfaction
Recording influenza vaccination
Addressing BMI
Improving HBA1C testing rate in Diabetic Clinics
Improving Documentation of CHF education
Improving Primary Care provider designation

UNIVERSITY OF UTAH
HEALTH CARE

"For many, many years, we've been working under the fantasy that if we come up with new drugs and new treatments, we're done. The rest of the system will take care of itself. In my view, the rocket science in health and health care is how we deliver it."

Jim Yong Kim, MD, President
Dartmouth College