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Interview of Dr. Paul Grundy

Director of Healthcare, Technology and Strategic initiatives for IBM Global Wellbeing Services and Health Benefits

President of the Patient-Centered Primary Care Collaborative

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David Harlow: Hello, this is David Harlow on HealthBlawg, and with me today is Dr. Paul Grundy, who is the Director of Healthcare, Technology and Strategic initiatives for IBM Global Wellbeing Services and Health Benefits. He is also President of the Patient-Centered Primary Care Collaborative, which is a group of large employers and primary care physician associations. Dr. Grundy has years of experience in government and in the healthcare industry and I am happy to welcome him today to HealthBlawg. Thank you, Dr. Grundy, for being with us.

Paul Grundy: Thank you for inviting me; it's a pleasure to be with you.

David Harlow: Well, I would ask if you could start off with a brief introduction on your experience with the patient-centered medical home initiative at IBM. What is it exactly? When you use that term what do you mean? How long has this been a project of IBM's and what kind of impact is it having both in terms of health status and cost savings?

Paul Grundy: So the concept of a change of the covenant between the buyer of healthcare and the provider of healthcare is at least some years old in reference to the concept of better primary care - more integrated, more comprehensive primary care. We as buyers of care really reached a conclusion that if we were going to really shift the curve or bend the curve as they call it now and we are going to begin to add the kind of value in the doctor-patient relationship that our employees were asking us to do, that it would take a transformation across the ecosystem, it would really take a change of covenant between the buyer and the provider of care, i.e., aligning payment at the macro level in exchange for micro-level transformation of practices to deliver better care.

So our employees -- or just in general, the patients -- what they really want, they want convenience, they want access, they want comprehensive care, they want relationship-based care. What they get now instead of that is they get episodes of care and what we buy is an episode of care, so: I can buy the kind of care that allows me to get pretty good amputation for my diabetic, but I can't buy the kind of comprehensive integrated care that prevents my diabetics from needing an amputation -- is sort of the line I have been using for the last four years, and it's still true. So we thought about that long and hard at IBM and certainly many other companies as well and some places have in essence created onsite facilities to do this, but since we have 60 percent of our employees that are scattered in every zip code and we really wanted to be equitable for all of our employees whether they happen to live next to a large IBM site or not. We really decided to take a different tack and that was to begin to have a conversation with the folks who should provide comprehensive care, i.e., the primary care providers, which do that in

most societies, and see if there was a way we could create a movement towards and ability for us to buy that kind of care across the spectrum.

So I guess about three years ago now we had 47 large employers that met with all of the primary care organizations and out of that meeting was born the joint principles of the patient-centered medical home, when the buyers said to the providers you need to agree on a set of principles around the concept of more robust, more comprehensive, more integrated care. So that's sort of the birth of the idea and the partnership between and buyers and the employers. It's now grown much larger, with well over 600 organizations that are part of it including hospitals, all the national health care plans, many of the large consumer groups, the employer associations and I think there is a total of 19 medical specialty groups that have endorsed the concept, etc. So it's grown to a rather large organization that's really fundamentally trying to drive change towards more comprehensive primary care.

We also are a global employer, as many large companies are, and we noted that in many societies, those who have really integrated comprehensive robust primary care as the basis of their health care delivery system seem to be happier, and obviously the healthcare costs are twice as much in our society as they are in any other society -- you know that's been quoted many times, but it's true.

David Harlow: Right. You mentioned the growth of the participation in the collaborative but from where I sit my perspective is that actual implementation of patient-centered medical homes has not been quite so wide spread and there is certainly a distance to go. I am wondering: From where you sit, how do you see this idea translating to the population at large? Or on what time frame? Are the demonstrations that are included in some of the health care bills wending their way through Congress an appropriate right next step from your perspective, or do we need to take bigger leaps at this point?

Paul Grundy: Well, the original concept when we first met after about a year of sort of sorting out our thoughts and directions in the partnership between the buyers and the providers, we asked the national health care plans into the room, because companies buy their health care through the 5 or 6 national health care plans, and some local ones as well, and we sort of thought probably the best way forward would be to really design some pilots around the concept, to kind of kick the tires to prove it out in various communities around the country, and so that led to a number of pilots beginning to evolve in the commercial marketplace. Some legislation was passed for it to occur in CMS although they haven't kicked off yet, but there are many pilots that are multi-stakeholder pilots with many health care plans that are rolling out. I think at last count there were a little over 100 that I counted rolling out around the country, of which a dozen or 20 or so are really pretty far along and pretty robust in terms of the scope and the size of the pilots.

But the concept was to build into these pilots pretty rigorous analysis, to look at them academically, to kick the tires with them, to see how the results would look and then, from what we learned, to move forward. Some of results are out on some of the early pilots at the first year and into the second year, and what we're seeing consistently across the dozen or so that are out is that indeed better upstream care -- i.e., better care coordination, better primary care, better prevention, better access into the primary care provider's office -- results in significant decline in the utilization of emergency rooms and hospital beds.

David Harlow: Yes, I saw some press recently about Group Health of Puget Sound --

Paul Grundy: That's correct, that's one of the early pilots, they now have data for two years; they have published for the first year.

David Harlow: Yeah and so they and a number of other sites have been experimenting with this.

Paul Grundy: That's correct.

David Harlow: Do you see differences across different pilot locations in the model being used, is there significant variation in the models being rolled out and tinkered with?

Paul Grundy: Well there is variation in what's looked at, there is variation in how it's rolled out. I think what's a pretty constant is just simply looking at applying better care coordination, on more robust primary care in an ambulatory setting, resulting in less need for hospital beds and emergency room utilization. What's been looked at has been different. For example, in North Dakota they looked at the disease diabetes with a much more coordinated approach to the care management of diabetics, and they resulted in about a $500 a year savings for each of the patients which they shared with the practices. That resulted in moving from a pilot to an actual roll-out across the state as we speak, which is what's happening with many of these pilots. The same in Geisinger. Geisinger did better care co-ordination, better upstream care looking at a range of chronic diseases for elderly people, and what they discovered was a 48 percent reduction in re-hospitalization, a 20 percent reduction in hospitalization, a 12 percent reduction in ER utilization, an ROI of 251 percent, significant savings and again what they have - the lesson that they've learned from that is that, they are going to now move beyond the pilots stage and roll it out across their system.

The same with Intermountain. Intermountain did it in a number of locations, saw the same kind of results. Those are integrated systems, and what we've seen in individual practices across the country -- and there's probably been over a hundred that I've visited – Javier is an example: he is a pediatrician down in Florida, single physician, 41 percent Medicaid and again better care co-ordination, better empowerment, better education of the patients, better access to the primary care team resulted in going from an average of about one asthmatic admitted to the hospital a week to none in 14 months, and that, when you carry that beyond United States and look globally at places that are really doing this, who are 10 or 15 years ahead of us, is exactly the pattern we saw.

I mean in Denmark, for example, it is a rare event now to hospitalize patients for chronic diseases because that's managed with better care co-ordination, better primary care, better care integration in a medical-home-type environment including, as migration occurs out, actually links to Wi-Fi equipment monitoring at the home, that sort of thing.

David Harlow: I was just going to ask about how this model interacts with some other sorts of initiatives, new developments. People talk about Health 2.0, for example, and you mentioned the Wi-Fi monitoring, and interactive connections. Do those sorts of tools help to enable the demonstrations to work more efficiently and effectively or are they too expensive in some cases?

Paul Grundy: No they are not. In many cases most of those kinds of things are in fact much less expensive than you know, than hospital rooms, right? I mean, a hospital is about the most

expensive place you can treat some of these diseases -- and by the way it's dangerous, it is not a place you want to go --

David Harlow: There's sick people in hospitals --

Paul Grundy: Yeah, you have sick people in hospitals and people get sick in hospitals, it's an unsafe place, so what I think is happening, frankly, and I think it is a 2.0 kind of issue, we really had a juncture in time when the docs will have the kinds of tools -- and we're already beginning to see them roll out -- that really empowers them from an outpatient sort of vantage point, with the control center really at their desk that has real information provided to them so, so some of this care, can and is done in it continuously and he has done virtually in which, in which you begin to have the kind of data flow that will empower the physicians minds the way X-rays empower their vision.

I mean it's that kind of transformation and in some places it's further along than others, some places in United States it's further along than others and if you look globally there are places where again, like the Danish model -- they have gone from 155 hospitals down to 25 -- it's just, again, a rare event to have the kinds of diseases that can be monitored remotely, and can be monitored with a more integrated approach to care, to have to put them in a hospital where they are in danger.

I mean it's a phenomenal change and that's exactly what the example of North Dakota was or what the example in Colorado was or in North Carolina. In North Carolina, the State of North Carolina and Community Care North Carolina began to focus on better care coordination integration and resulted in, I think it was, a 44 percent reduction in the number of patients that were hospitalized for asthma, the same story that we talked about, and these aren't integrated systems by any stretch of the imagination; these are folks that are eligible for Medicaid. And the same in Colorado: very similar results within the Medicaid population with, again, better upstream care resulting in lower downstream cost.

David Harlow: Are there any particular sets of incentives that you can generalize about that are proven to be most effective in yielding desired results?

Paul Grundy: I think aligning payment around what it is you want to buy, right? I mean, we currently align payment around buying stuff; if a bill is submitted for doing stuff we pay for it. What we find is that when you begin to align incentives around paying for care coordination, care integration -- for example in the United States most docs don't have a clue who their patients are even and they don't have a sense of responsibility for making sure that all of them have their colonoscopies done or their breast exams done or their immunizations done because here there is no sense of: I am responsible for that.

So you need to align that. So one of the alignments that other societies have done, and other integrated systems have done or the VA in United States has done is that they basically incent the patients and the docs and by aligning them in a location where both agree that that's their home, that's where there medical records are and somebody is responsible, they have got a target on their back to make sure they don't die of breast cancer, because they are getting their breast screens, right? I was visiting a clinic in Spain and I saw a - I went in to the doc's work room and they were three names on the board and I said to one of the docs there, who are those names and

she said well, those are three women in the community that after sending them an e-mail, after mailing them, after phoning them, they still haven't got their breast exam, so we are sending a car out today to make sure that it wasn't for our failure to make sure that they have got their screening exams, that they die of breast cancer.

That kind of community-based responsibility in aligning payment around that I think is key for a system to really work; I know we have the most mal-aligned system in the world --

David Harlow: Yes, it clearly needs a lot of work --

Paul Grundy: That's why we are twice as expensive as anybody in the world. One part of the reason, it's kind of like the Olympics a few years ago, where we got the very best players in the world and we have a really good well trained physicians here. We have really excellent hospitals, medical schools etc., and we put them on the court, the basketball players, and we got whipped – right? – by somebody, I can't remember who it was, but mainly the fact was we didn't play together as a team, we couldn't throw the ball. I mean, that's what happens every day in our health care delivery system, we have nobody, nobody, coordinating care. I mean somebody can have five specialists and you know one's doing the exact opposite of what the other is doing and nobody is talking to each other, right?; it's really dangerous.

David Harlow: Right. So you've alluded to some of your experiences and what you have seen in other places around the world and I know you had a lot of other experiences around the world in earlier parts of your career and I am wondering which of these examples that you've seen or other experiences from your past do you particularly draw on and look at in developing this model further.

Paul Grundy: Well, this is not even around the world, it's here as well. I mean, one of the major systems here in United States that's really driven a lot of inefficiency out of the systems - the Veterans' Administration - they moved from a basically hospital-based system to an outpatient, primary care based system with clinics, 700 or so locations around the county, really with the focus on comprehensive integrated care and just drove tremendous efficiency and resulted in the highest patient satisfaction of any of our health care delivery systems in the United States.

A phenomenal change given my experience in training in their hospitals earlier in my career and if you look at, and if you look at other models of care here like Geisinger and Kaiser, some of the integrated systems, they really do well - the statistics show that if you are in a integrated system where somebody just pays enough attention to make sure that you take your aspirin, that your blood pressure is controlled and you take your Lipitor, or your lipid lowering agents that you know you have one third less likelihood of having a myocardial infarction than somebody age-adjusted in a system where nobody is coordinating your care. It's a phenomenal difference. I mean we have twice as many heart surgeons and heart surgeries in this country and I think you know part of the reason why we need to is that we fail to provide robust primary care and prevention.

If you want to look globally at systems that are really taking this model I would have to say first that in my looking and studying and reading about this, it's really an American model that sort of went global. It's kind of the like the Japanese model that came back to America and when they asked where it came from they said it's the Wharton school of business, right? The Danes came

here under a Harkness fellowship and the Commonwealth Fund, studied what was going on at Kaiser, read the pediatric literature about medical home kind of went back to Denmark and designed a system and they really focused on that and you know they are one of the few countries in the world --

David Harlow: They actually did it?

Paul Grundy: They actually did it: one of the few countries in the world that actually has a curve of cost trends downward, I mean downward - not go-broke upward like our system is - downward and again it's not very hard, it's not very difficult, it was putting money into the front end of this system developing a robust system of prevention and primary care, putting the technology and the tools to really do more effective management at the level of the doctor-patient relationship in the primary care delivery system. Spain is gone from being 19th in the world to fourth with the same transformation; in the meantime, according to the study in Health Affairs that I've read we've gone to 19th of 19 developed economies, dead last.

David Harlow: Yeah so it's troubling. So do you see an opportunity and a role for government-led health reform along these lines? What you have been describing to me is really private-payor-driven and integrated-delivery-system-driven developments in the direction of the patient-centered medical home. Is the job done? Is the job close to being done? Do we need the government to step in? How can it help?

Paul Grundy: Well to be frank and blunt, absolutely honestly, that's the kinds of dialogue we've had at the level of the White House in the recent roundtable where we were discussing this and in fact I'm in Washington today visiting some of the folks on the Hill about this. Why? Because how health care is delivered in our country is so dependent on how CMS buys health care, I mean that's 50 percent of the spend --

David Harlow: Sure, as the biggest buyer, yeah --

Paul Grundy: Yeah, so when we try to buy health care and we don't buy it in a model of health care that's around how CMS buys it, it makes it very difficult for us, the non-government buyer. We can buy it in integrated systems but that only accounts for about 6 percent of the places where we can buy, right? Much of the country, even if I tried I couldn't buy the kind of care that's available at Geisinger, I just can't buy it --

David Harlow: Right, let's have the systems in place --

Paul Grundy: So we have to help virtualize what those guys do, look at what they do and virtualize it -- that's Health 2.0, that's, taking a primary care doc and helping him have the kinds of tools that would allow a simple registry -- the ability to track diseases -- the ability to be compensated for tracking diseases, the ability for payment reform to occur, where they actually get paid for having an e-mail, an asynchronous conversation with my patients to do follow up, they are only paid now for face-to-face encounters and the reason why they are paid that way is because that's how Medicare buys, right? That's, that's my dilemma, that's all of our dilemma.

David Harlow: Right, and there are certainly demonstrations looking at bits and pieces of this, and there is hope …. For example, in my home state, Massachusetts, we're looking at a global payment transition over the next five years.

Paul Grundy: Yeah, Massachusetts is doing some very exciting things and I think there is quite a bit of interest in the medical home there. I was just recently meeting with some of the leadership on this in the state and there is a lot of excitement on the one hand, and the other hand they are closing primary care training programs at Harvard. It's very interesting, but what our system values, what they pay a lot of money for, is procedures and not for the kinds of relationship-based care, the kind of healing arts, that prevent procedures from being necessary.

David Harlow: Right, and as you say, we really need to reform that at a more global level --

Paul Grundy: Yeah, that's going to take a national effort and that's going to take a real emphasis on priorities but other countries have done it, and in having done that they are very successful. I mean the VA has done it, right?

David Harlow: Yes, yeah that's really transformed the VA --.

Paul Grundy: I mean they are continuing to look at improving it as we speak but I mean the amount of progress they've made is phenomenal.

David Harlow: Yes, so you mentioned the White House roundtable. I wanted to ask about that did you find that to be a productive encounter? Did you feel that folks were listening? And in your current visit, do you feel that there is an opportunity to make an impact?

Paul Grundy: Absolutely. I think there is a great deal of interest -- the video's out there on C-Span or you can YouTube White House roundtable and find it -- but what they really did was present seven or eight of these early pilots and some of the results and then had a conversation around it and I think that the White House came away with the realization that there was a whole lot more happening on the ground than they even were aware of -- and they were aware of a lot – and, by the way, on the political spectrum there is interest in this, this whole transformation which is different than reformation on both sides of the aisle, I mean Grassley has been very supportive of it in recent meetings that we have with him in Iowa, Hatch in Utah has been extremely supportive of it.

There are medical home pilots that are going on at the Medicaid level in just about every state and so regardless of whether they are red or blue states this whole drive for transformation is really got a lot of steam.

David Harlow: So what's your prognosis, Paul? Do you think that in five years from now, do you think this will be more fully diffused through the country? Do you think we need national legislation in order to implement this --

Paul Grundy: Well I think we first of all we are getting national legislation, because there is language in both the Senate and House around this. I think certainly the White House sees the importance of more robust primary care and prevention, which is really what we are talking about, with the technology underneath to drive it, and I think in five years we will have a much clearer picture of the value of this in non-integrated systems. I think in five years we will have a very clear picture of it in integrated systems, where already we are getting to see the evidence of that, you know and I think we'll be in a place perhaps of some desperation -- given the Massachusetts experience of reformation without transformation -- i.e., more folks that need

primary care without access to it, because the infrastructure is not in place to deliver it effectively.

David Harlow: Well, thank you very much, Paul. I wonder, before we wrap up, if there is anything else that you like to share with us today about the state of the art, or your vision for the future of the patient-centered medical home.

Paul Grundy: I think you covered it very well. I have a sense of real optimism. I am a glass-half-full kind of guy and I have a sense of real optimism that we are really beginning to see some transformation at the ground level and that physicians and the patients in practices where this has happened are happier patients, happier physicians and more effective care turns out to be actually cheaper care or more valuable care.

David Harlow: Right -- and hopefully nobody can argue with that. Well you have heard it here, folks: Dr. Paul Grundy glass-half-full kind of guy speaking with us today. He is the President of the Patient-Centered Primary Care Collaborative and Director of Healthcare for IBM Global Wellbeing and Health Benefits. Paul, I appreciate you taking the time to speak with us today, thank you very much.

Paul Grundy: Thank you very much, it's only a pleasure.