Patient-Centered Primary Care COLLABORATIVE

NATIONAL MEDICAL HOME SUMMIT: Opening Joint Plenary

Marci Nielsen, PhD, MPH

Chief Executive Officer, PCPCC

Monday March 17, 2014

Defining the medical home

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

Patient-Centered
Supports patients in managing decisions and care plans.

Comprehensive
Whole-person care provided by a team

Coordinated
Care is organized across the 'medical neighborhood'

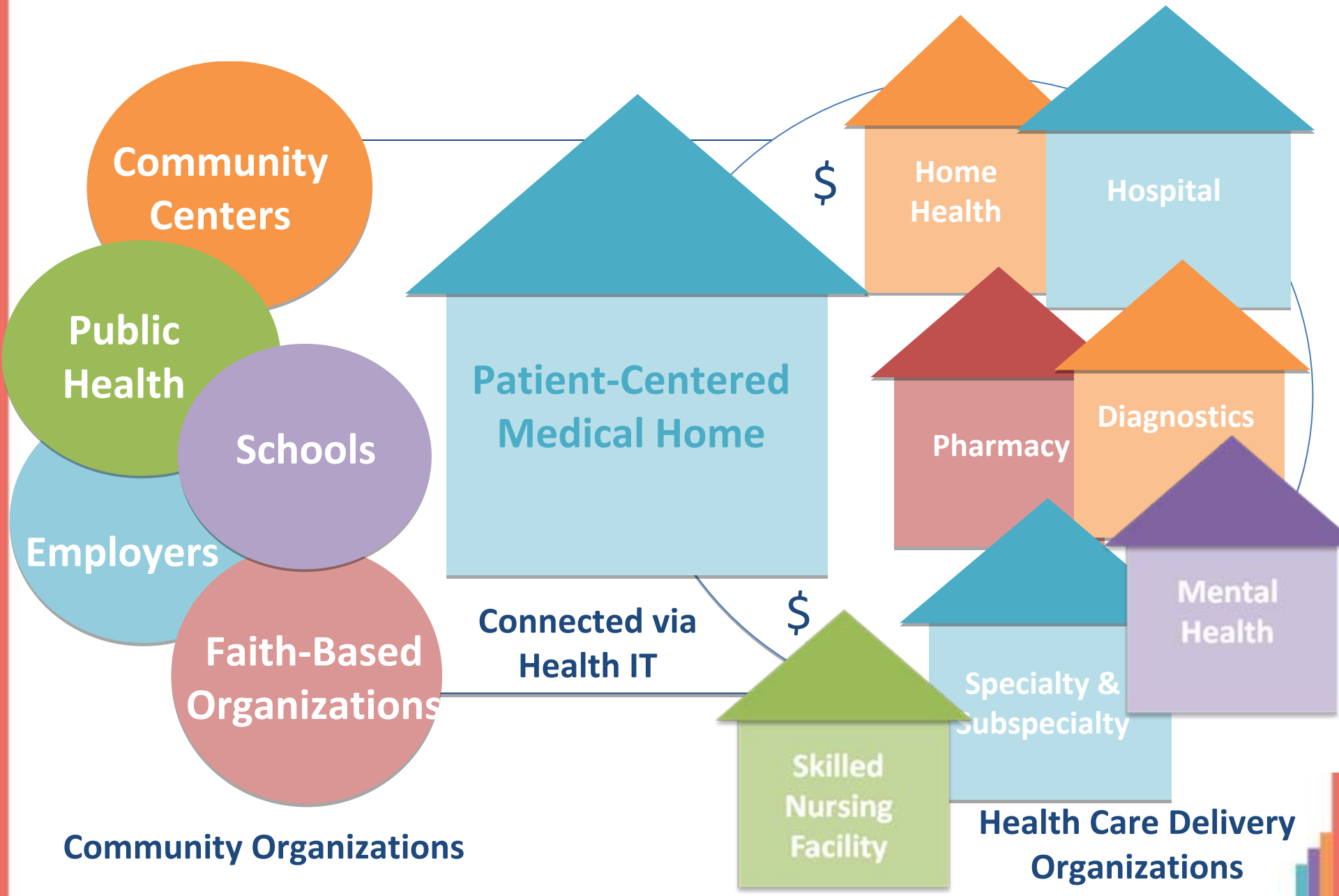
Committed to quality and safety
Maximizes use of health IT, decision support and other tools

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

Source: www.ahrq.gov

The reports of our death are a wee bit exaggerated.

The Medical "Neighborhood



If everyone doing their part…
Everything is Awesome!

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NATIONAL MEDICAL HOME SUMMIT: Opening Plenary: The Current Landscape

Marci Nielsen, PhD, MPH

Chief Executive Officer, PCPCC

Monday March 17, 2014

What's the message?

- It's marxist
- It's anti-marxist
- It's pro-business
- It's anti-business
- It's a radical paradigm shift and Hollywood's answer to the Occupy movement

http://nypost.com/2014/02/12/5-secret-political-meanings-hidden-in-the-lego-movie/

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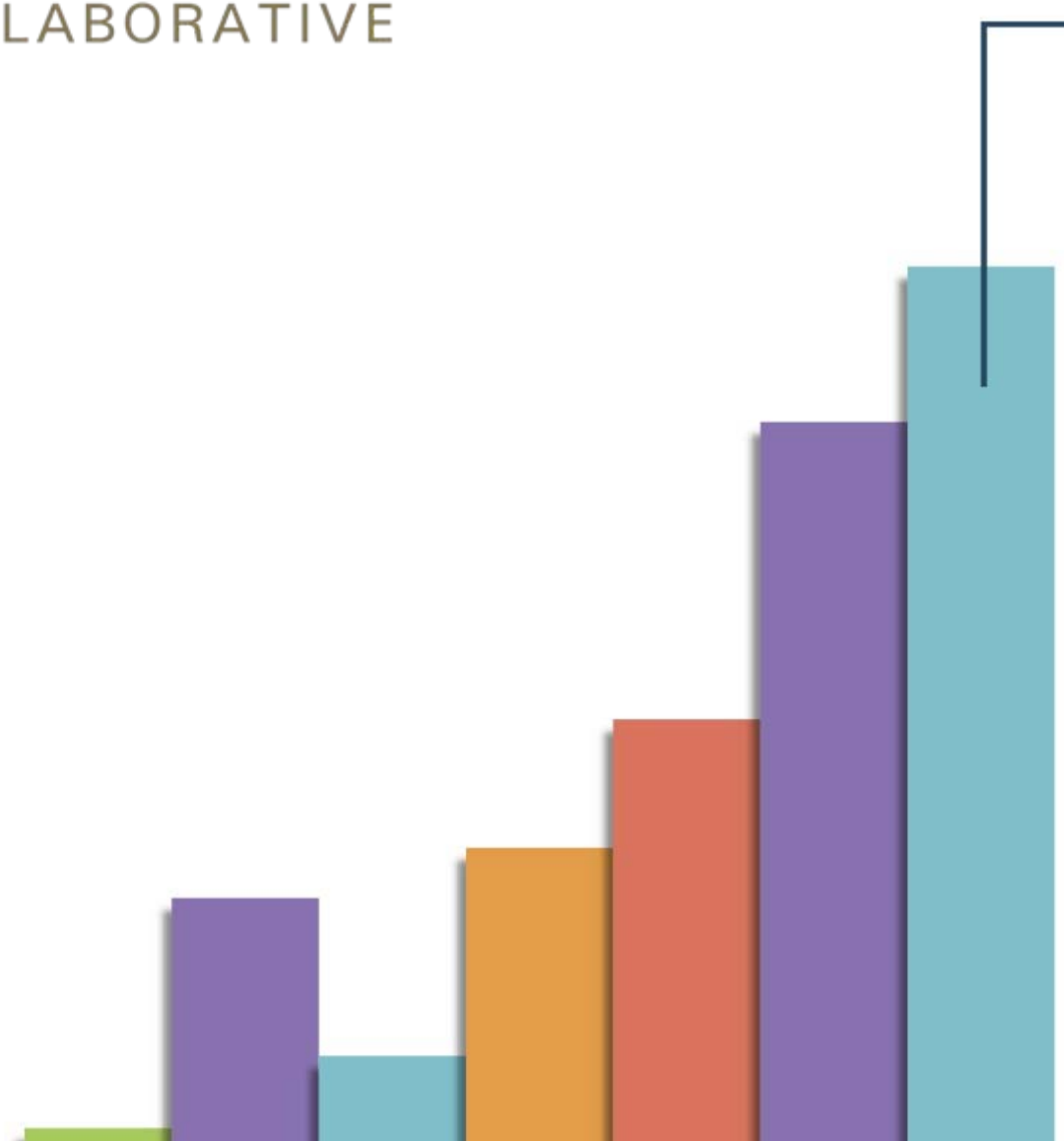


The Patient-Centered Medical Home's Impact on Cost & Quality:

An Annual Update of the Evidence, 2012-2013

January 2014

Key Point #1:

PCMH evaluations report improvements across a broad range of clinical and financial outcomes

PCMH **Peer Reviewed** Outcomes

- 61% of studies report cost reductions
- 61% report fewer ED visits
- 31% report fewer inpatient visits
- 13% report fewer readmissions

Cost & Utilization

- 31% of studies report improved access
- 23% of studies report improved patient satisfaction

Care Experience

- 31% of studies report increase in preventive services
- 31% report improvements in population health

Health Outcomes

PCMH **Industry Generated** Outcomes

- 57% of studies report cost reductions
- 57% report fewer ED visits
- 57% report fewer inpatient visits
- 29% report fewer readmissions

Cost of Care Utilization

- 14% of studies report improved access
- 14% of studies report improved patient satisfaction

Care Experience

- 29% of studies report increase in preventive services
- 29% report improvements in population health

Health Outcomes

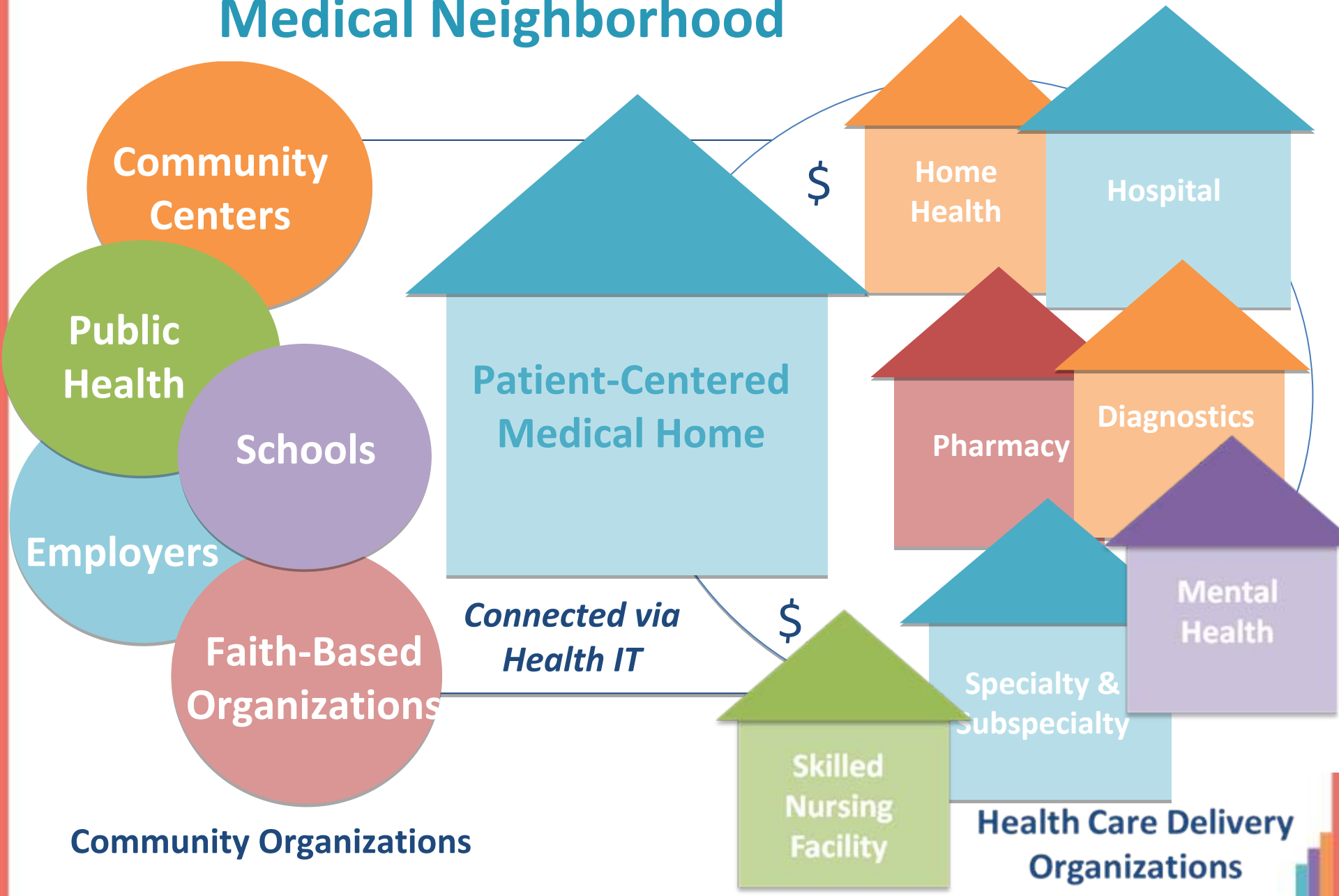
The Challenge of Studying the PCMH

- Right metrics?
  - Gap in **clinician satisfaction measures** – tied to workforce needs
  - Need for better/more **patient measures** of engagement and self-reported health status/well-being
  - Measures need to account for **patient diversity**
  - Need for standard **core measures – including behavioral health integration**
- Right methods?
  - Study designs appropriate for investigating complexity of health system reforms
  - Recognition that the model/philosophy is evolving

Key Point #2:

PCMHs play a critical role in delivery system reform, including ACOs and the medical neighborhood

PCMH: Foundation to ACOs & the Medical Neighborhood



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NATIONAL MEDICAL HOME SUMMIT: Mini Summit II: Health Plans Support for the Medical Home

David Nace, MD

Chair of the Board, PCPCC

Tuesday, March 18, 2014

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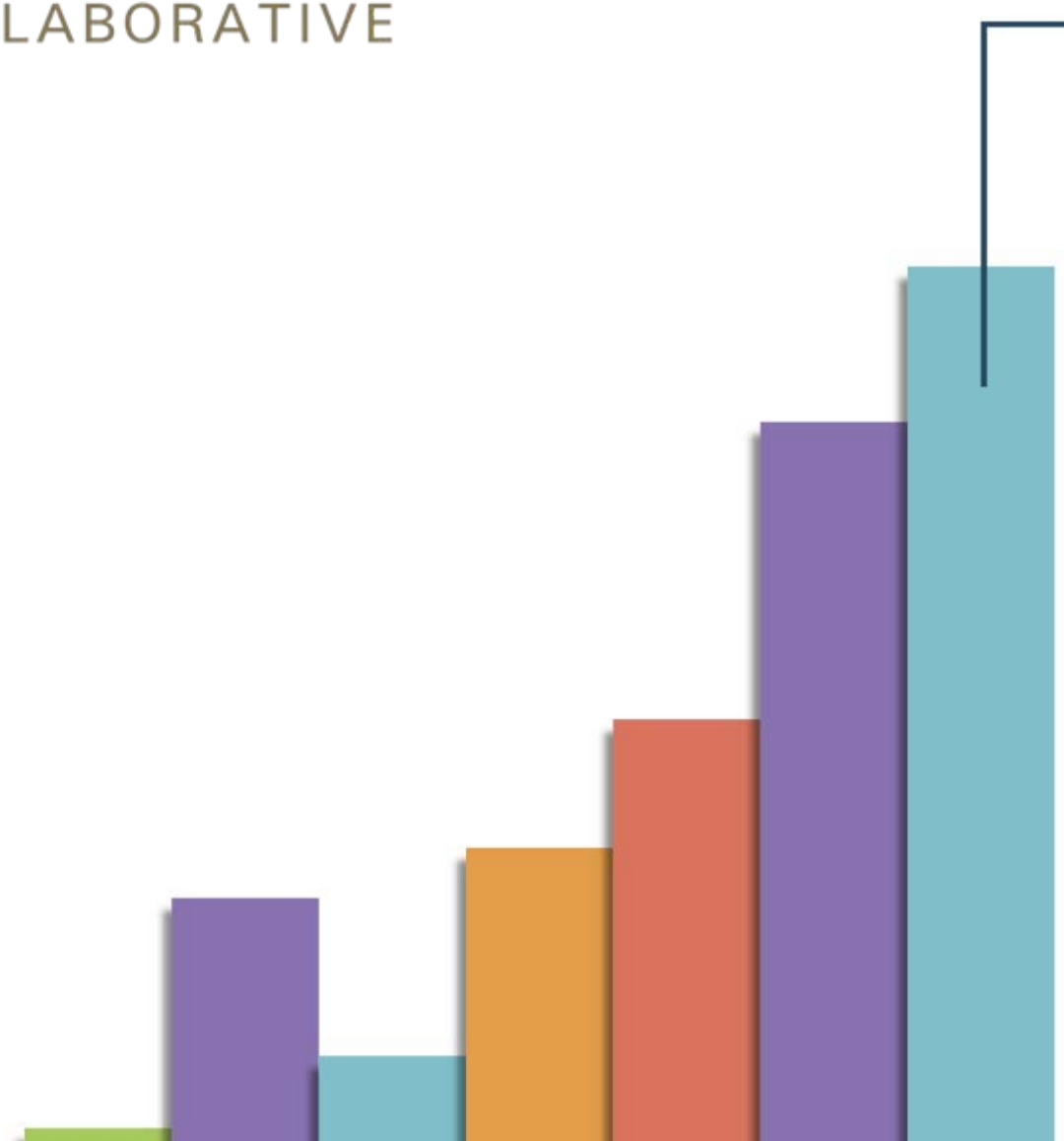

The Patient-Centered Medical Home's Impact on Cost & Quality:

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January 2014

Key Point #3:

Significant payment reforms continue to incorporate the PCMH

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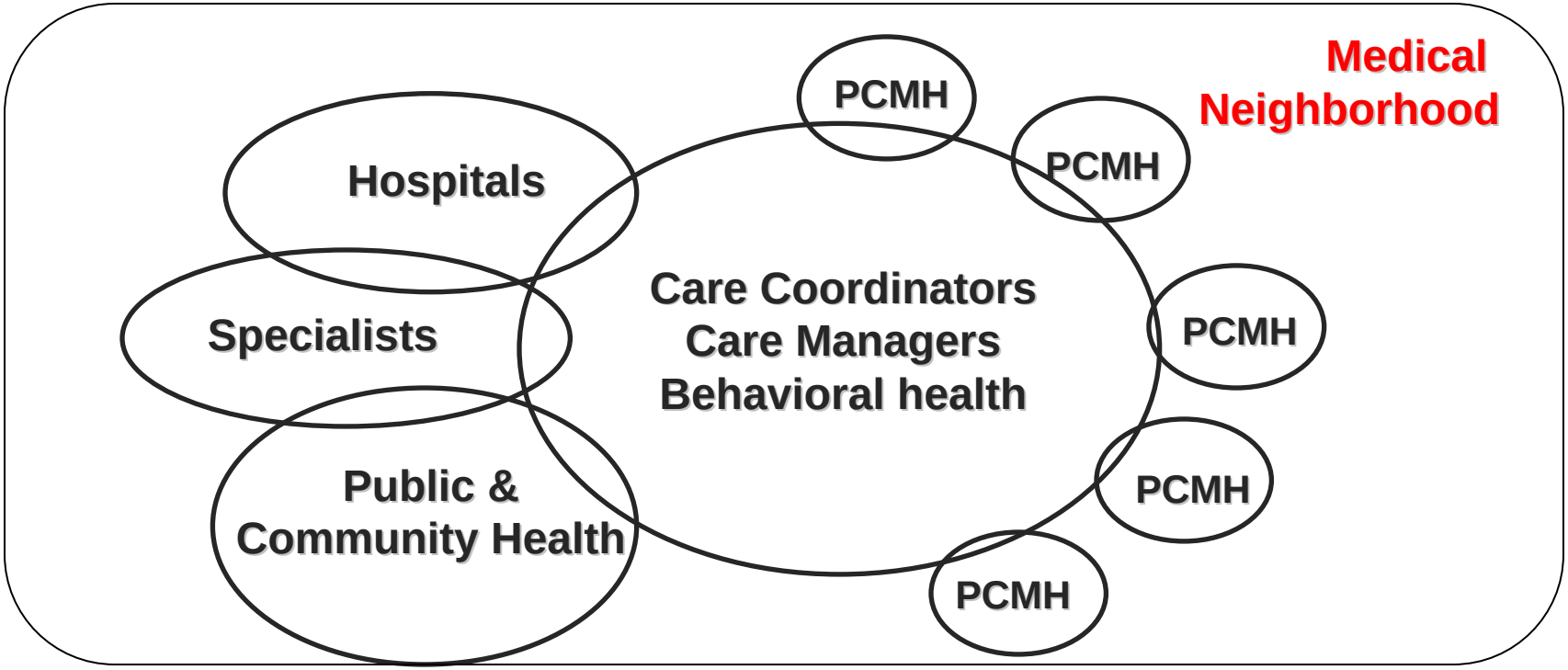
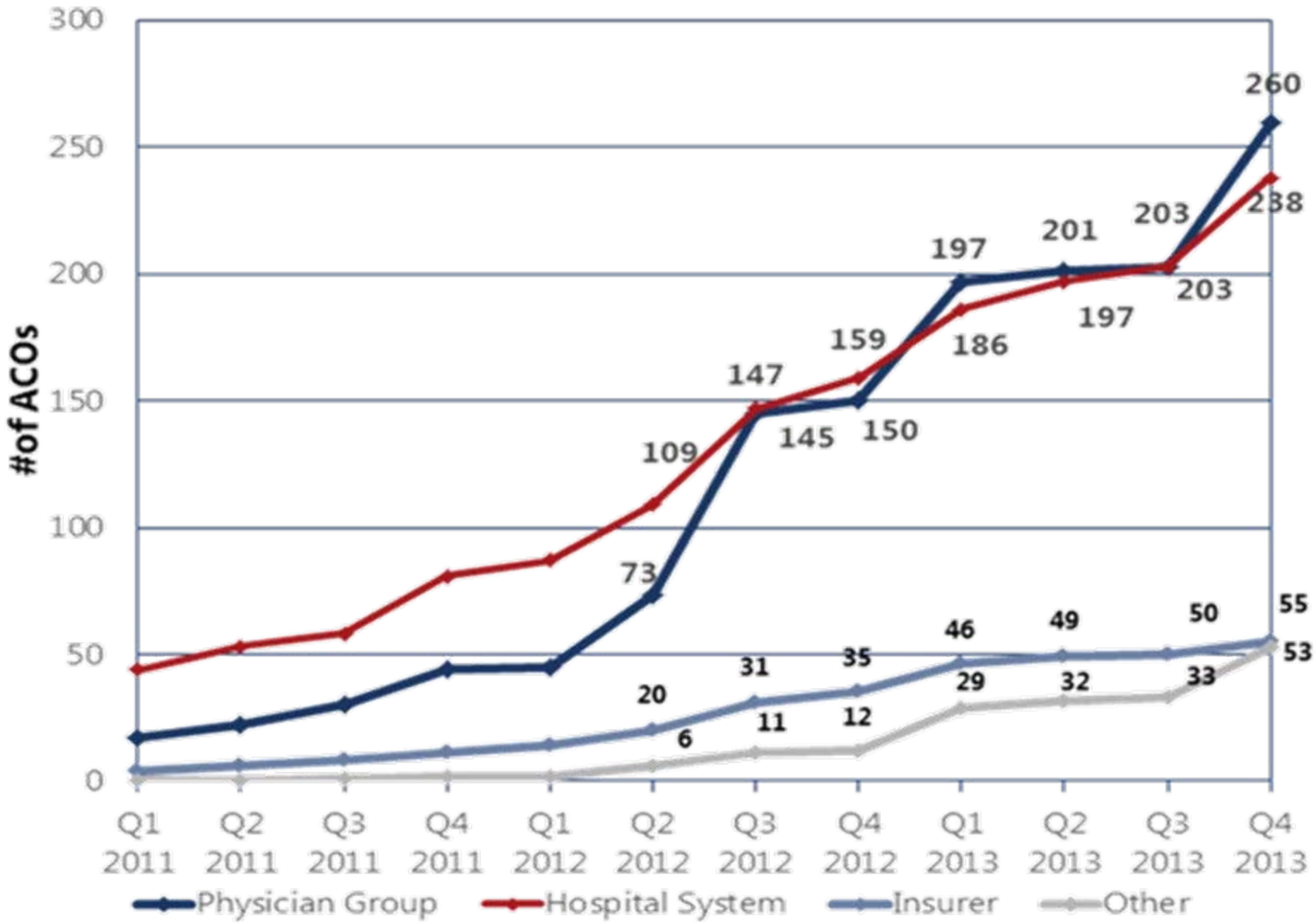
PCMH and Accountable Care: Joining Forces

Accountable Care



Health IT Infrastructure

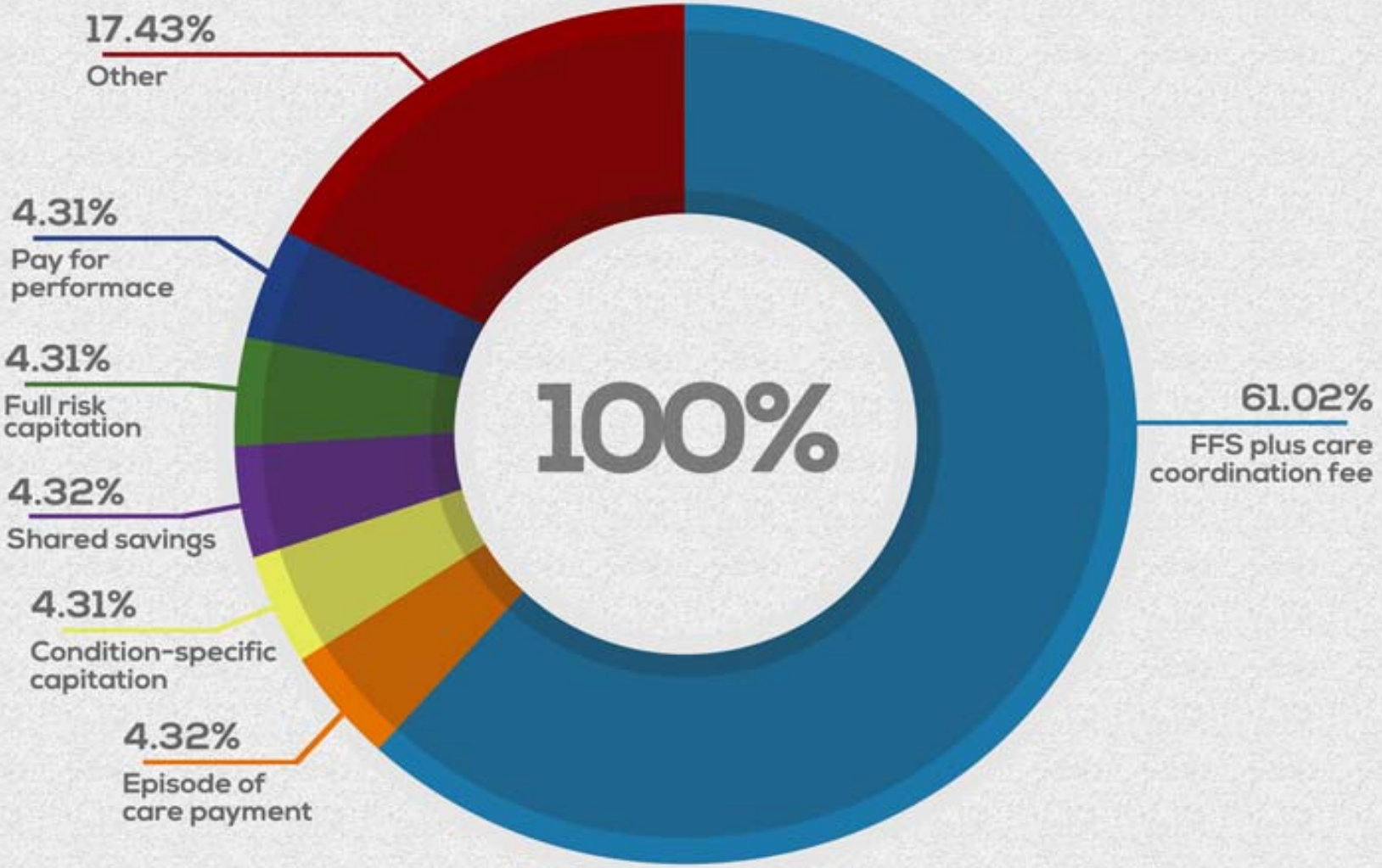
ACO Growth Since 2011



http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/

REIMBURSEMENT MODELS USED IN PCMH PROGRAMS

Reimbursement models vary among different PCMH models,
but majority embrace fee-for-service (FFS) plus care coordination fees.



AHIP
America's Health Insurance Plans

Alternative Delivery and Payment Models—Private Sector Initiatives

NOTE: Icons may represent multiple partnerships within the state

CMS Innovation Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement

- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation

- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

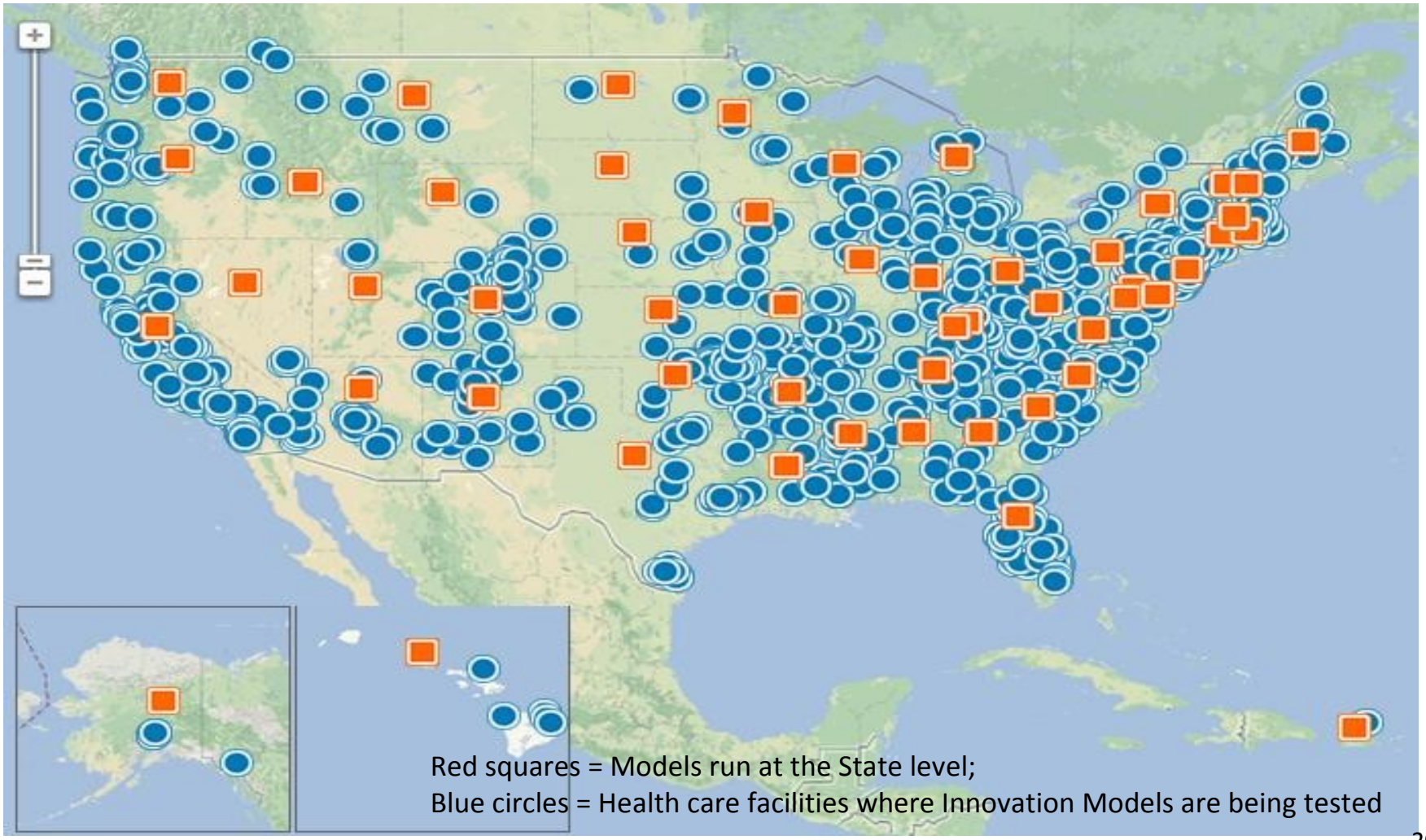
Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

Innovation is happening broadly across the country



Red squares = Models run at the State level;
Blue circles = Health care facilities where Innovation Models are being tested

Mini Summit II: Health Plan Incentives and support for the Medical Home

- Independence Blue Cross
  - Richard Snyder, MD
- UPMC Health Plan
  - Deborah Redmond, MBA, MHA, RPT
- Capital District Physicians Health Plan
  - Eileen Wood, RPh, MBA
- Priority Health
  - Mindy Olivarez, MBA
- Anthem Blue Cross Blue Shield – Connecticut
  - Peter Bowers, MD

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NATIONAL MEDICAL HOME SUMMIT: Closing: What we have learned & Where we go from here

Marci Nielsen, PhD, MPH

Chief Executive Officer, PCPCC

Wednesday March 19, 2014

Explaining all this to the public

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Transformation Lessons Learned

- **A strong foundation is needed for successful redesign.**
  - Broad organizational support, previous experience with teams, financial stability, focus & commitment with few distractions
- **The process of transformation can be a long and difficult journey.**
  - Ambitious & challenging and requires time, dynamic & time intensive with ebbs and flows, requires deep changes in structures and systems, tensions & trade-offs should be expected
- **The approaches to transformation vary.**
  - Increased use of team-based care, expanded patient access & improved coordination, data-driven measurement & feedback, formal or informal learning collaboratives

Source: McNellis RJ, Genevro J, Meyers DS (2013) Lessons learned from the study of primary care transformation. Annals of Family Medicine

Transformation Lessons Learned

- **Visionary leadership and a supportive culture ease the way for change.**

  Communication with staff & patients, cultural attributes (collaboration, respect, accountability), alignment of incentives & rewards, mission based focus

- **Contextual factors are inextricably linked to outcome.**

  National, state, & local policies, dynamics of the health system or related systems, influence of the community & other stakeholders, financial incentives, staff dynamics & characteristics, approach to transformation

Source: McNellis RJ, Genevro J, Meyers DS (2013) Lessons learned from the study of primary care transformation. Annals of Family Medicine

Role of the Collaborative

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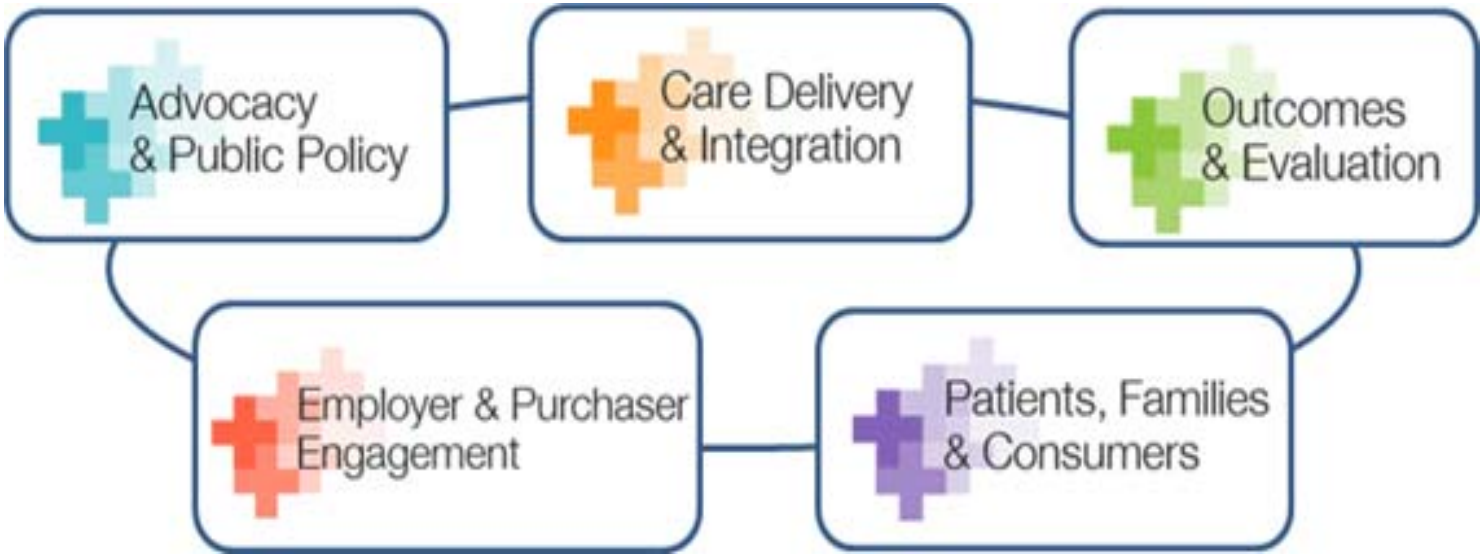
- **Challenge** the status quo and **drive** the marketplace
- Disseminate timely **information and evidence**
- Provide **networking & educational opportunities**



PCPCC Upcoming Events

- June 9-10th, 2014
- Denver, Colorado
- PCPCC, HealthTeamWorks, CO Academy of Family Physicians

- November 12-14th
- Washington DC
- Patient-Centered Primary Care: At the Heart of Value and Quality

2014 PCPCC
Western Regional Conference

2014 PCPCC
Annual Fall Conference

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