Joint Plenary: Population Health Colloquium & Medical Home Summit

Patient-Centered Primary Care COLLABORATIVE

Marci Nielsen, PhD, MPH

CEO, PCPCC

March 23, 2015

National Imperative: "Triple Aim"

Better Patient Experience

"Triple Aim"

Lower Per Capita Health Care Costs

Improved Quality (better outcomes)

Source : Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." *Health Affairs* 27.3 (2008): 759-769.

Patient-Centered Primary Care COLLABORATIVE

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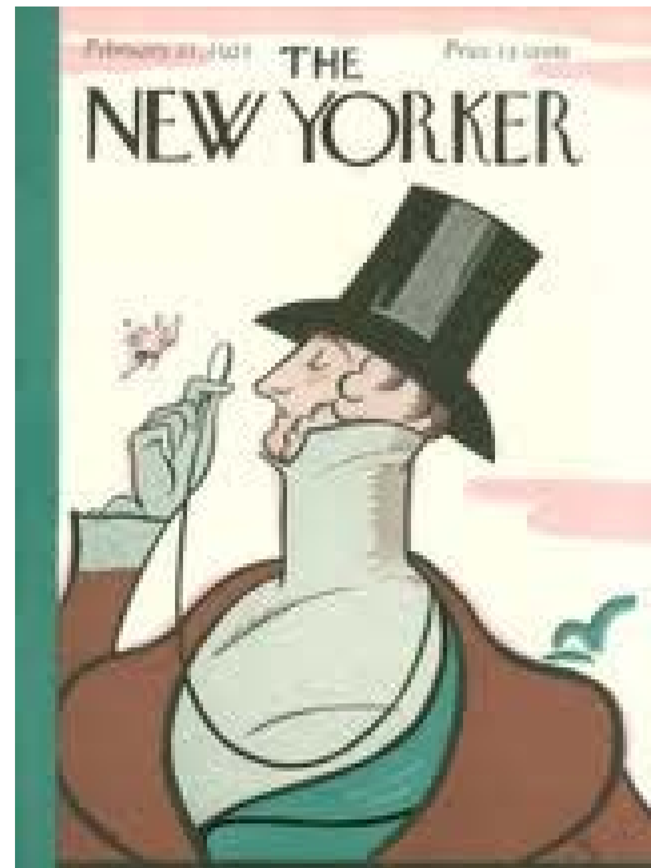
ATUL GAWANDE, MD, MPH

Harvard Professor, Surgeon, Writer,
Public Health Researcher

Atul Gawande, MD, MPH

- Born: 1965, Brooklyn, NY
- Education: Balliol College (1989), Stanford University (1987), Harvard (MD, MPH)
- Additional facts: MacArthur Fellowship; nomination for National Book Award for Nonfiction, New Yorker author



ATUL GAWANDE, MD, MPH

Harvard Professor, Surgeon, Writer,
Public Health Researcher

MARCI NIELSEN, PHD, MPH

Chief Executive Officer, PCPCC

Coincidence?!

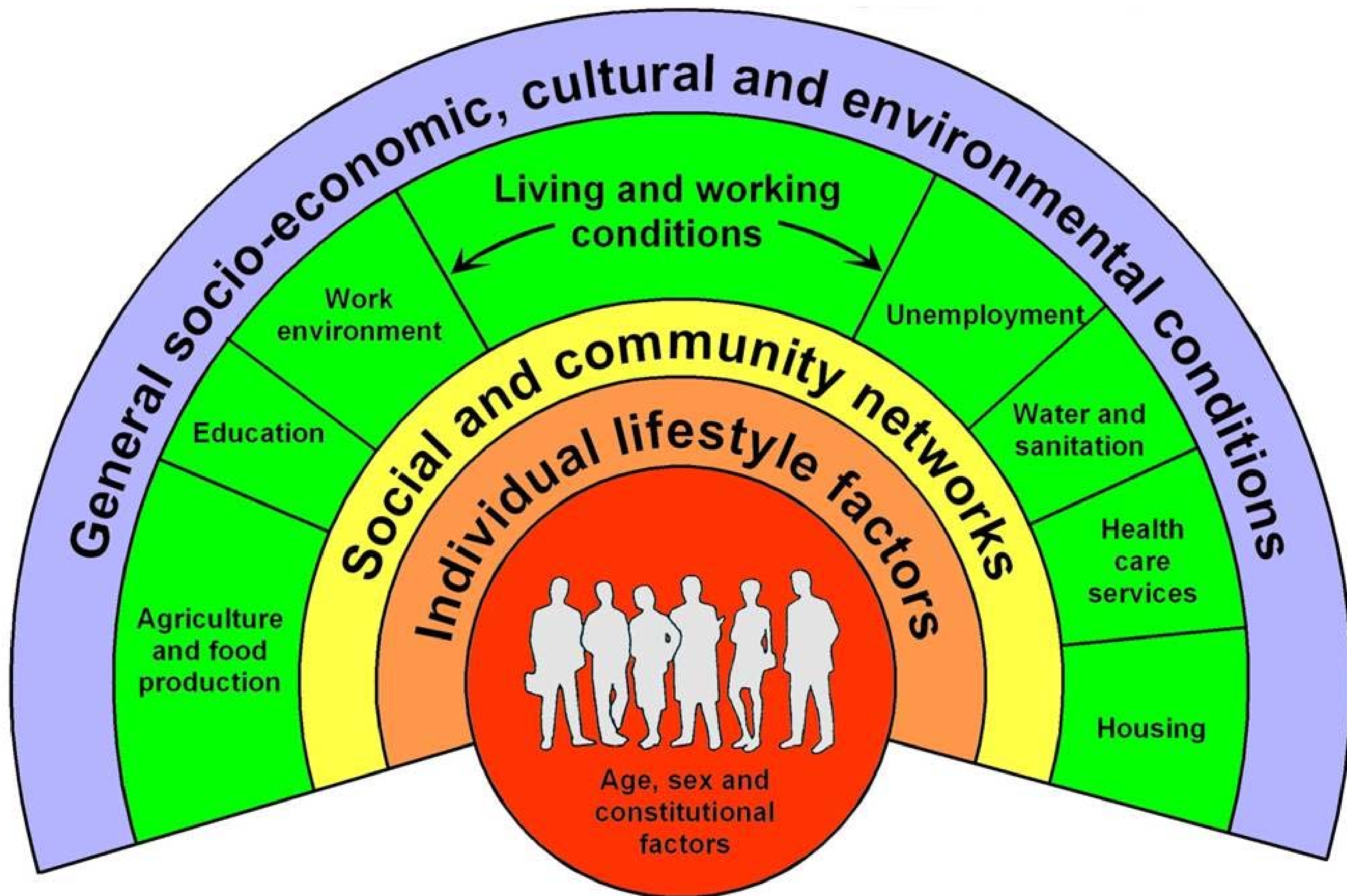
Atul Gawande, MD, MPH

- Born: **1965**
- Education: **B**alliol **C**ollege (1989), Stanford University (1987), Harvard (MD, MPH)
- Wrote a speech called "Cowboys and Pit crews"

Marci Nielsen, PhD, MPH

- Born: **1965**
- Education: **B**riar **C**liff (1987), George Washington University (1994), Johns Hopkins (PhD)
- Live in a state with ***real live cowboys and pit crews***

So what's "our story"?



Study Authors:

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- Amy Gibson, RN, MS
- Lisabeth Buelt
- Paul Grundy, MD, MPH
- Kevin Grumbach, MD

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PCMH Peer-Reviewed Outcomes

14 PEER-REVIEWED STUDIES

10 reported on cost, 6 found improvements

13 reported on utilization, 12 found improvements

3 reported on quality, 2 found improvements

4 reported on access, 4 found improvements

4 reported on satisfaction, 4 found improvements

- Medicare FFS (NCQA PCMH)
- Veterans Affairs (PACT)
  - (4 studies)
- Florida Medicaid
- Illinois Medicaid
- Kentucky – Ft. Campbell
- New York Presbyterian Regional Health Collaborative
- Community Care North Carolina
- Pennsylvania Chronic Care Initiative
  - Rand
  - Independence BCBS (2 studies)

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Oregon Coordinated Care Organizations

Location/Initiative	Cost & Utilization	Population Health & Preventive Services	Access to Primary Care Services	Patient or Clinician Satisfaction
Oregon				
Oregon Coordinated Care Organizations (CCO)[53] ***Published:*** *Oregon Health Authority*, June 2014 ***Data Review:*** 2011 (comparison group); 2013 (PCMH group)	• 19% reduction in ED spending • 17% reduction in ED visits • 5% reduction in all-cause readmission rates **Decreased hospitalization for chronic conditions:** • 27% reduction for patients with CHF* • 32% reduction for patients with COPD* • 18% reduction for patients with adult asthma	• 58% increase in percentage of children screened for risk of developmental, behavioral, and social delays • Increase in screening, intervention and referral for treatment for alcohol or other substance abuse (from 0% to 2%) • 5% improvement in LDL screening in patients with diabetes • Increase in follow up care after hospitalization for mental illness (from 65.2% to 67.6%) • Improvement in all 3 components of medical assistance with smoking and tobacco use cessation	• 52% increase in enrollment in patient-centered primary care homes since 2012 • >20% increase in spending for primary care and preventive services • 11% increase in outpatient primary care visits • Increase in adolescent well-care visits (from 27.1% to 29.2%)	• Increase in patient satisfaction with care (from 78% to 83.1%)

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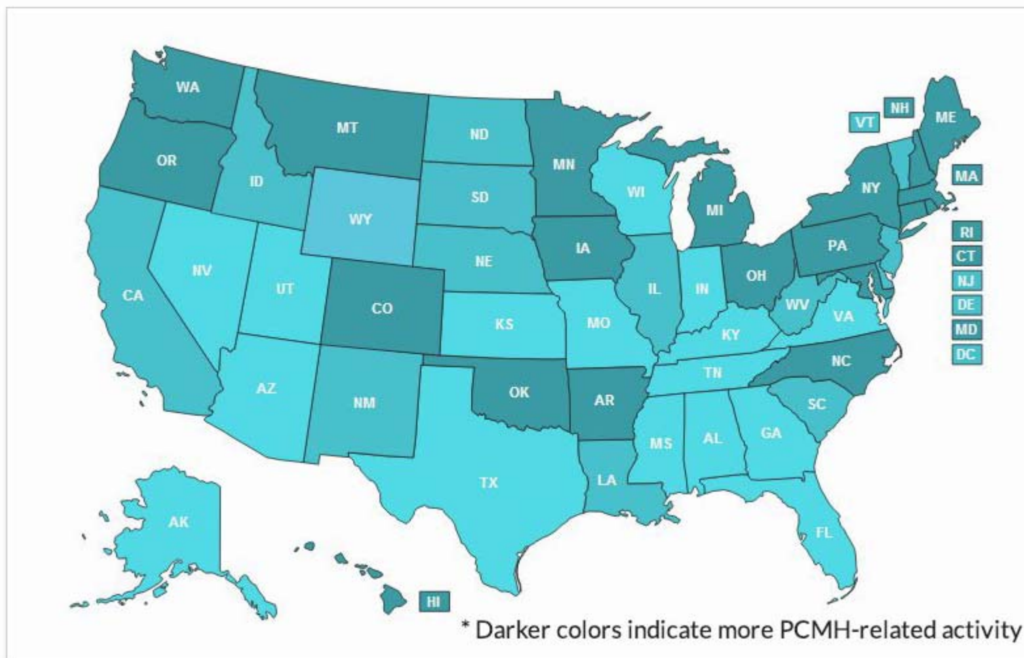
Primary Care Innovations and PCMH Map

List View
State View
National View
Outcomes View
FAQ Page

Mapping the Medical Home Movement:

This map includes a diverse range of programs using patient-centered medical homes (PCMH) and enhanced primary care teams as the model for improving health care delivery. Click the map for a summary of all public and commercial PCMH programs in the State (State View). For more information on what programs are included visit our Frequently Asked Questions (FAQ) page.

State View



* Darker colors indicate more PCMH-related activity

What is a Medical Home?

Join our mailing list for the latest map updates and medical home news.

New Opportunities!

- Evaluations from Comprehensive Primary Care Initiative (CPC) and Multi-payer Advanced Primary Care Program (MAPCP)
- HHS Secretary announcement to move Medicare into value based contracts (from 20 to 50% by 2018); creation of the Healthcare Payment Learning & Action Network
- Private sector leaders form new "Health care transformation task force" committed to putting 75% of their businesses in value based arrangements by 2020
- ONC announcement on new push for health information technology interoperability by 2017

THE STORY SO FAR

TulsaShootout

Adding real people to real data (and sticking with your twin – or at least your friends)

@MustafaAlavi
More Primary care = Less Hospital Admissions.
Join the national campaign.
#MakeHealthPrimary #FMRevolution #grandma