Patient-Centered Primary Care Collaborative
and the National Patient Centered Medical Home Movement

Amy Gibson, MS, RN
Chief Operating Officer
Patient-Centered Primary Care Collaborative

November 2012
Primary Care in the early days . . .
Primary care of the future . . .

Patient/Family Medical Home
- Team-based
- Coordinated
- Comprehensive
- Accessible

Data Warehousing & Mining
Patient and Provider Portals
EHR Connectivity & Interoperability
Data Registries & Decision Support
Schools
Community Health
Long Term Care
Pharmacy
Palliative Care
Health Plans
Acute Care
Home Health
Specialty Care
Family Supports

Team-based, Coordinated, Comprehensive, Accessible
Milestones in PCMH Development

1967-2006

1967
- Alma Alta Declaration

1978
- Medical Home Term in Standards of Child Health Care by Council on Ped. Practice

1979
- Medical Home and Hawaii Child Health Plan (Calvin Sia, MD)

1989

2002
- AAFP & TransforMED

2004
- Future of Family Medicine

2006
- ACP & Advanced Medical Home

2006
- PCPCC Founded

ACP & TransforMED

Patient-Centered Primary Care Collaborative
Milestones in PCMH Development

2006-Present

- National Business Group on Health Award
- Joint Principles of PCMH
- Commonwealth Fund PCMH Programs
- NCQA PCMH Recognition

2007
- Commonwealth Fund PCMH Programs

2008
- State & Local PCMH Pilots

2010
- Affordable Care Act

2012
- Wellpoint PCMH National Launch
Health care expenditure per person
by source of funding, 2007*

*Adjusted for Differences in Cost of Living

Source: OECD Health Data 2009 (June 2009)
Opportunity cost for investments

OECD Health Data, 2009. Life expectancy at birth in different countries versus per capita expenditures on health care in dollar terms, adjusted for purchasing power. The United States is a clear outlier on the curve, spending far more than any other country yet achieving less.
Research shows significant variation in health care spending.

Chart 1: Medicare Spending per Beneficiary, by Hospital Referral Region, 2006

Conservatively, 30% of the annual $2.5 trillion U.S. health expenditure is estimated to be waste, equating to approximately $700B each year.

### Key sources of waste

<table>
<thead>
<tr>
<th>Source of Waste</th>
<th>% of Total Medical Cost that is Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin and System</td>
<td>4 - 6%</td>
</tr>
<tr>
<td>Provider inefficiencies</td>
<td>3 - 4%</td>
</tr>
<tr>
<td>Lack of care coordination</td>
<td>1 - 2%</td>
</tr>
<tr>
<td>Unwarranted</td>
<td>11 - 21%</td>
</tr>
<tr>
<td>Preventable conditions and avoidable care</td>
<td>1 - 2%</td>
</tr>
<tr>
<td>Fraud and abuse</td>
<td>5 - 8%</td>
</tr>
</tbody>
</table>

1. Thomson Reuters, 2011
# A Change in Paradigm

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating Sickness / Episodic</td>
<td>Managing Population</td>
</tr>
<tr>
<td>Fragmented Care</td>
<td>Collaborative Care</td>
</tr>
<tr>
<td>Specialty Driven</td>
<td>Primary Care Driven</td>
</tr>
<tr>
<td>Isolated Patient Files</td>
<td>Integrated Electronic Record</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Evidence-Based Medicine</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>Shared Risk/Reward</td>
</tr>
<tr>
<td>Payment for Volume</td>
<td>Payment for Value</td>
</tr>
<tr>
<td>Adversarial Payer-Provider Relations</td>
<td>Cooperative Payer-Provider Relations</td>
</tr>
<tr>
<td>“Everyone For Themselves”</td>
<td>Joint Contracting</td>
</tr>
</tbody>
</table>
Transformation requires...

- Delivery Reform
- Payment Reform
- Benefit Redesign
- Public Engagement
Movement To Accountable Care

Accountable care requires physicians to change how they deliver care and to work with other providers and payors in collaborative ways.

Anchored on the patient-centered medical home

Key Elements to Achieve Accountable Care

- Significant care coordination between providers caring for a patient
- Ability to collect and share information across care givers and patients
- Performance transparency across the system and stakeholders
- Shifting to a primary focus on patient health & care outcomes rather than on transactions/intensity of services
Standards for PCMH

National Committee on Quality Assurance (2008)
- Practice level recognition; data used by payers

Joint Commission (2011)
- Primary Care Medical Home certification

URAC (2011)
- Patient Centered Health Care Home Practice Achievement accreditation
- Health plan focused

Accreditation Association for Ambulatory Health Care (2011)
- Accreditation with Medical Home (comprehensive survey of overall organization including Medical Home)
- Medical Home On-Site Certification (survey focused on joint principles of MH)
<table>
<thead>
<tr>
<th>PCMH Initiative</th>
<th>Health Care Cost &amp; Acute Care Service Measures</th>
<th>Health Outcomes &amp; Quality of Care Measures</th>
</tr>
</thead>
</table>
| Horizon Blue Cross Blue Shield of New Jersey (2012) | • 25% fewer inpatient hospital admissions  
• 26% fewer ED visits                                                                                           | • Improved diabetes control by 8%  
• Screenings for breast and cervical cancer also increased by 6%.                                         |
| Group Health Cooperative in Seattle        | • 29% fewer ED visits  
• 6% fewer inpatient hospitalizations  
• Savings of $10.3 per patient per month after 21 months                                                             | • Clinical quality (HEDIS) measure improvements ranged from 30-40%                                           |
| Geisinger (2012)                           | • 25% fewer hospital readmissions  
• 53% fewer readmissions  
• Estimated return on investment of 2:1                                                                          | • Improved quality of preventive care (74%), coronary artery care (22%), and diabetes care (34.5%)            |
<table>
<thead>
<tr>
<th>PCMH Initiative</th>
<th>Health Care Cost &amp; Acute Care Service Measures</th>
<th>Health Outcomes &amp; Quality of Care Measures</th>
</tr>
</thead>
</table>
| Vermont Blue Print for Health (2011) | • Lower inpatient admissions (range of 39.7% to 15.3%)  
• Lower ED admissions (range 33.8% to 2.8%) | • Increase in visits for chronic care & behavioral health |
| CareMore (2011) Medicare Advantage (California) | • 24% lower inpatient admission rates (compared to Medicare average)  
• 15% reduction in overall health care costs | • 97% patient satisfaction  
• Hospital stays 38% shorter  
• Amputation rate for diabetics 60% lower |
| Pediatric Alliance for Coordinated Care (Boston) | • Reduction of inpatient hospitalization from 57.7% to 43.2% (post implementation)  
• Reduction of parents’ missed work (>20 days) from 26% to 14% | • Increased satisfaction with health care delivery (68.4% easier to talk with same nurse, 60.9% easier to talk with doctor, 60.5% easier to get access) |
Robust State/local PCMH Activity

- 42 Medicaid programs and numerous local/regional activities
- State maps:
  - NASHP
    - http://www.nashp.org/med-home-map
  - AAP
    - http://www.medicalhomeinfo.org/state_pages/
Commercial Insurance
PCMH Buy-In

- Wellpoint
  - Nationwide roll-out

- BlueCross BlueShield
  - 39 states participating in PCMH initiative

- Aetna
  - CT, NJ – plans to go nationwide

- Humana
  - 10 states

- UnitedHealthcare
  - Value-based purchasing for 50-70% of their market
The Patient-Centered Primary Care Collaborative

- Mission is to advance effective and efficient health system built on a strong foundation of primary care and patient-centered medical home (PCMH).
- 1,000 members representing diverse stakeholders and growing

Paul Grundy, MD
Future Role of The Collaborative

- Continue to Lead from the front
  - Challenge the status quo
  - Disseminate timely information
  - Provide networking & educational opportunities
  - Develop and promote innovations in patient-centered primary care
Moving the PCPCC Forward

1. Clarify roles and streamline activities through new Center structure
2. Engage Executive Committee in visioning process
3. Develop sustainable business plan
4. Develop pro-active coordinated communications strategy
PCPCC Org Chart

- Operations Committee
- Board of Directors
- Finance Committee
- Executive Committee
- Employer & Purchaser Engagement Center
- Care Delivery and Integration Center
- Patient, Family & Consumer Center
- Advocacy & Public Policy Center
- Outcomes & Evaluation Center
- Taskforces
- Special Interest Groups
- Event Planning (Annual Mtgs)
- Publications
Employer and Purchaser Engagement Center

*Increase implementation of the patient-centered medical home, built on a strong primary care foundation among employers, purchasers and payers*

- Assist employers, health plans, and labor unions and their employees/members in accessing PCMH
- Assist human resource leaders, consultants, and brokers in various organizations about the value of primary care & the PCMH
- Engage large and small employers, including corporate leaders, on the benefits of primary care & the PCMH
Across the health care delivery system, increase implementation of the PCMH and support the development of Accountable Care initiatives with PCMH at their core

- Support integration of the PCMH into ACO’s and other models consistent with the medical neighborhood
- Develop resources/strategies to educate the care team on PCMH implementation and ways to engage patients and their families in practice transformation
- Improve utility of HIT functionality for the care delivery system, administrative staff and patients, families & consumers
Among patients, families and consumers, increase engagement and support for primary care and the patient-centered medical home

- Define patient engagement and include the perspective of patient and families
- Develop resources/strategies for patients regarding the role of primary care and the PCMH in health system transformation
- Develop strategies that include patients and families in PCMH evaluation and quality improvement
- Develop resources/strategies to address health disparities, health literacy, and cultural competency as part of the PCMH.
Increase adoption of policies that advance primary care and support implementation and sustainability of the PCMH.

- Develop advocacy and public policy agenda
- Advocate for and assist in the development of strategies to drive health system reform
- Promote primary care and the PCMH as the foundation for the medical neighborhood, Accountable Care Organizations (ACOs), and health system integration
- Promote the PCMH as part of federal and state health insurance exchanges, Medicaid, Medicare, and other federal, state, regional and local government health programs
Outcomes and Evaluation Center

*Demonstrate the value of primary care and the patient centered medical home, using appropriate data analysis and evaluation methods*

- Develop resources/strategies to obtain, aggregate, track, trend and analyze information from a variety of sources on medical home cost, quality, and population health outcomes
- Disseminate outcome data specific/relevant to the Centers, general members, and the public through a variety of resources/strategies
- Advance the refinement of outcome measures to promote PCMH continuous improvement
Task Forces

Task Forces will address *specific* activities or tasks on a *time limited* basis that are interdisciplinary

- Proposed Task Forces include:
  - Education and Training
  - Wellness and Prevention
  - Meaningful Use
  - Data and Resource Mapping
Special Interest Groups

SIG’s will provide informal networking and educational opportunities on major functional areas/sectors that are interdisciplinary

Proposed SIG’s include:
- Behavioral health
- Medication Management
- eHealth
Continue to Deliver Resources and Networking Opportunities

- Publications
- Website
- Webinars
- In-person Conferences and Meetings
PCPCC Publications

- Provides nationwide results from 34 recent peer reviewed and industry reports
  - health care costs
  - acute care services
  - quality of care
- Provides additional information on 23 case studies outlining specific features of a PCMH
SAVE THE DATE

Fifth National Medical Home Summit
March 13-15, 2013
Philadelphia, PA

Partnership between PCPCC and
Jefferson School of Population Health

Two-Day Annual PCPCC Conference
October 13-15, 2013

Hyatt Regency Bethesda
One Bethesda Metro Center
Contact Information

www.pcpcc.net

Marci Nielsen, PhD, MPH
Executive Director
mnielsen@pcpcc.net

Amy Gibson, MS, RN
Chief Operating Officer
agibson@pcpcc.net

Patient Centered Primary Care Collaborative
The Homer Building
601 Thirteenth St., NW, Suite 430 North
Washington, DC 20005
(202) 417-2081