Patient-Centered Primary Care COLLABORATIVE

Advocacy & the Patient-Centered Medical Home

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Ad·vo·ca·cy ˈadvəkəsē

Noun: public support for or recommendation of a particular cause or policy. "their advocacy of traditional family values“

synonyms: support for, backing of, promotion of, championing of; More the profession or work of a legal advocate.

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So what are “we” advocating for? (Or what’s the problem we are trying to solve?)

- https://www.youtube.com/watch?v=k7VH9ykZSB0

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About PCPCC – or "the Collaborative"

Our Mission

- Dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home.

Activities

- **Strengthening public policy** that advances and builds support for primary care and the medical home
- **Disseminate results and outcomes** from medical home initiatives and their impact on outcomes, quality and costs
- **Convene health care experts** and patients to promote learning, awareness, and innovation of primary care and the medical home

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History of PCPCC

National not-for-profit coalition founded in 2007 to:

- Facilitate achievements toward the Triple Aim: better health, better care experience, and health care cost control
- Create a more effective and efficient model of healthcare delivery, grounded in primary care

Acts as conveners to bring together thought leaders and stakeholders to address challenges, opportunities, and barriers to health system transformation

- Contributed to developing PCMH language for health reform proposals
- Published dozens of reports

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Membership

Since 2007, PCPCC membership has grown to represent more than 1,300 organizations providing care to 50 million Americans, including:

- Provider associations
- Large employers
- Health plans
- Providers & health systems
- Pharmaceutical firms
- Policymakers
- Patient advocacy groups

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Role of the Collaborative

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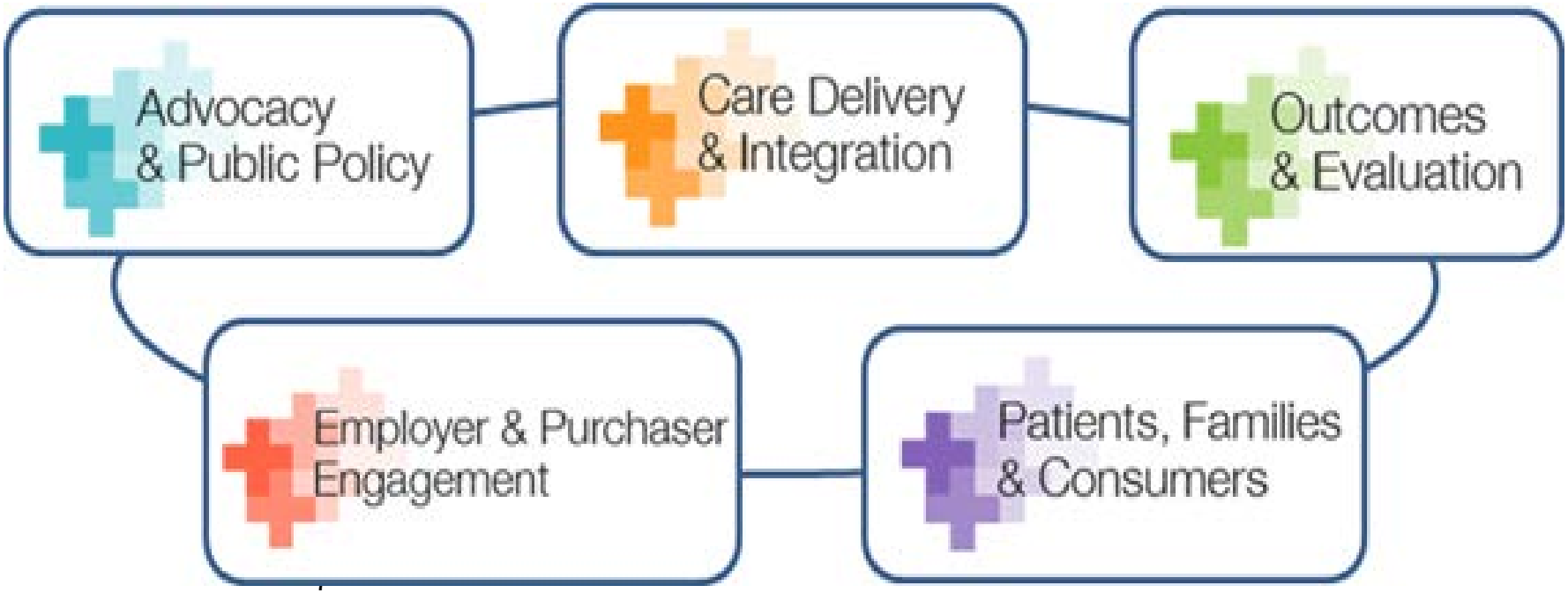
- **Challenge** the status quo and **drive** the marketplace
- Disseminate timely **information and evidence**
- Provide **networking & educational opportunities**



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Advocacy and Public Policy Center

Activities & Priorities

The Advocacy & Public Policy Center is dedicated to working closely with policymakers, agencies and government leaders at the state and federal levels to drive health system reform that incorporates key features of the medical home. The Center shapes PCPCC's policy and advocacy agenda and works with health care stakeholders to support meaningful policies related to Accountable Care Organizations, health insurance exchanges, health information technology, and payment reform.

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An advocacy strategy has to answer the following questions

- What change do we want to bring about?
  - What is going wrong? Evidence?
  - What must change? Alternative?
- Who can make the change?
  - Who has the power?
  - Who are our allies and opponents?
- How can you make them change?
  - How are we going to win?
  - How will we see if the change has happened?

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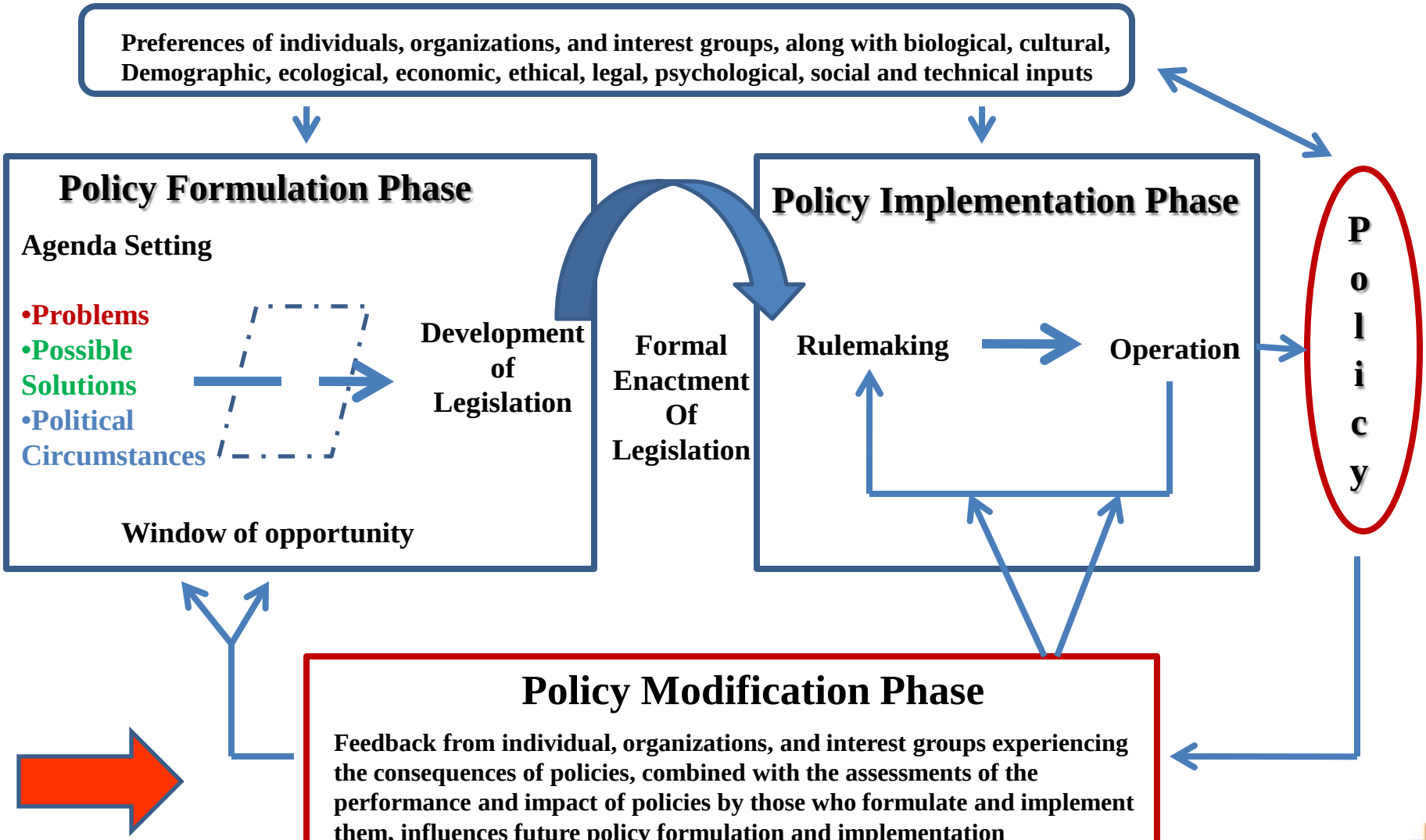
Longest Model of Public Policymaking



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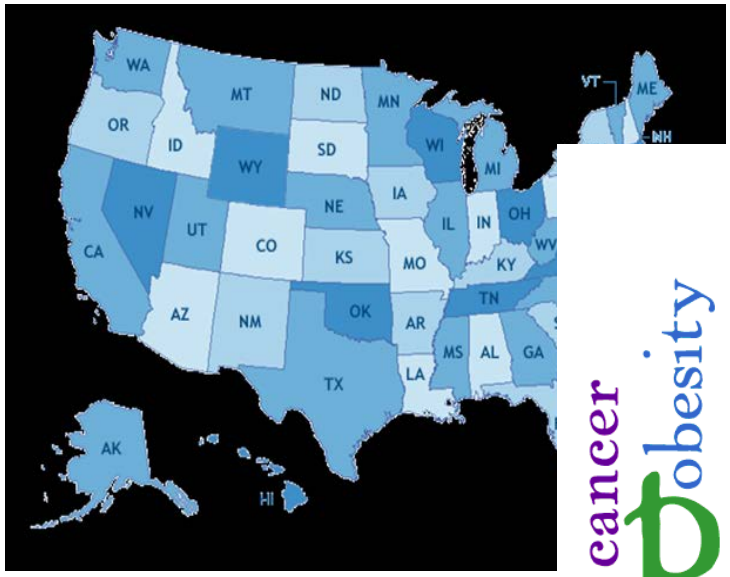
State and Federal Public Policy



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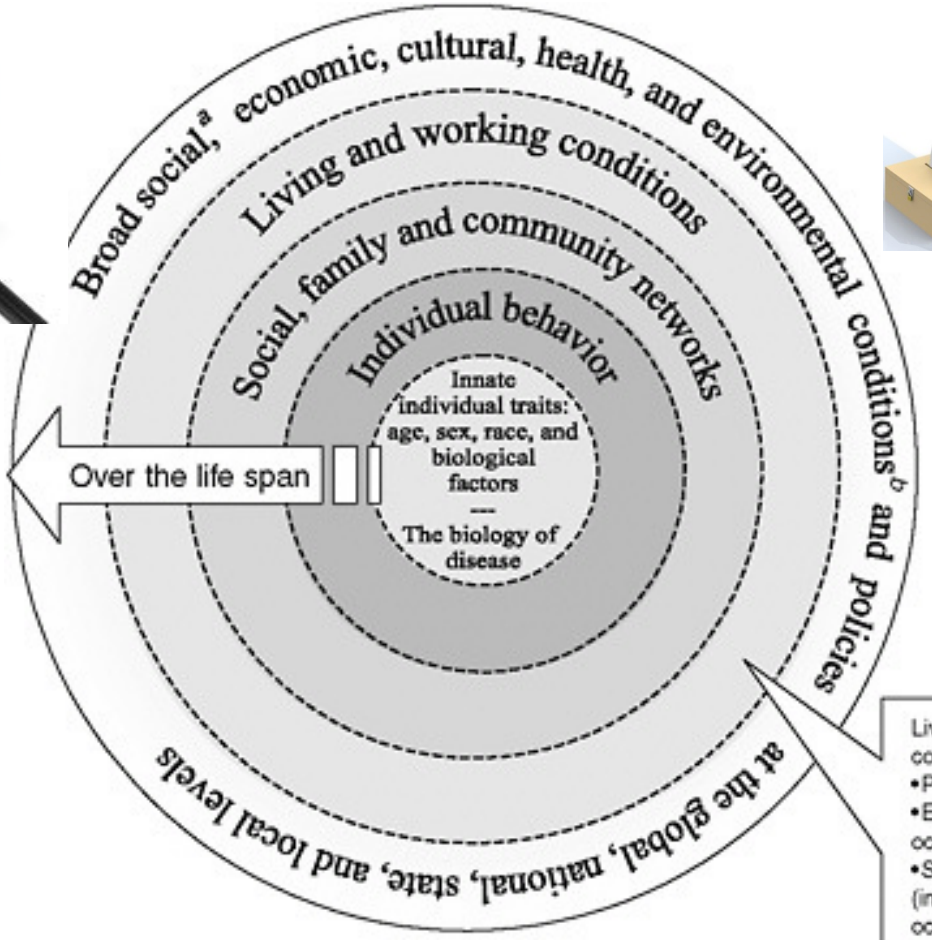
Patient = Consumer = Voter



IOM (2002); modified from Dahlgren and Whitehead (1991)

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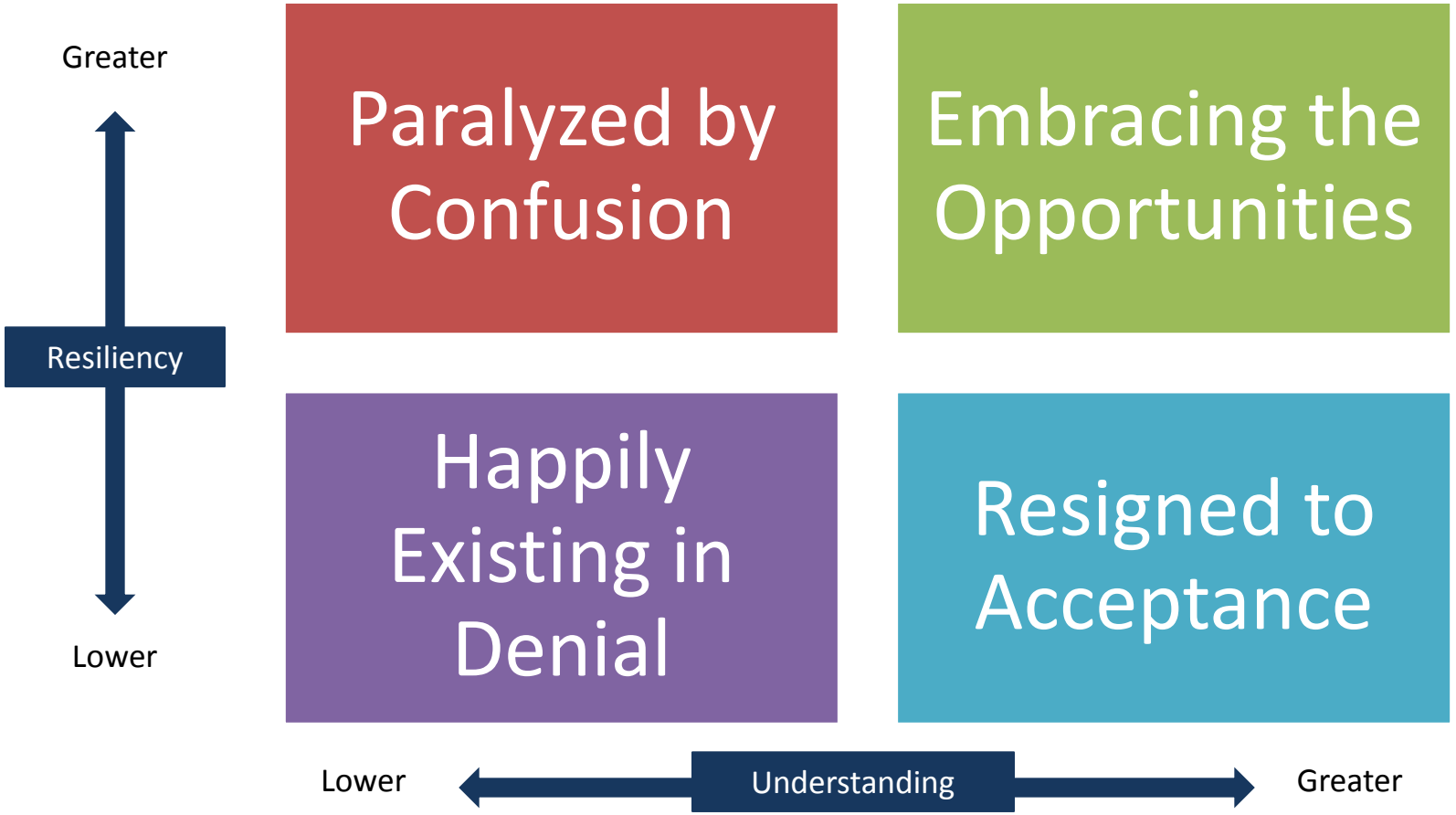
The Four Camps of Leadership in Health Care Policy



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Everyone doing their part…
Everything is Awesome!

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Health System transformation requires…

Delivery Reform

Public Engagement

Payment Reform

Benefit Redesign

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Changing to a new Paradigm

Today	Future
Treating Sickness / Episodic	Managing Populations
Fragmented Care	Collaborative Care
Specialty Driven	Primary Care Driven
Isolated Patient Files	Integrated Electronic Records
Utilization Management	Evidence-Based Medicine
Fee for Service	Shared Risk/Reward
Payment for Volume	Payment for Value
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations
"Everyone For Themselves"	Joint Contracting

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Defining the Medical Home

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

Person-Centered
Supports patients and families 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

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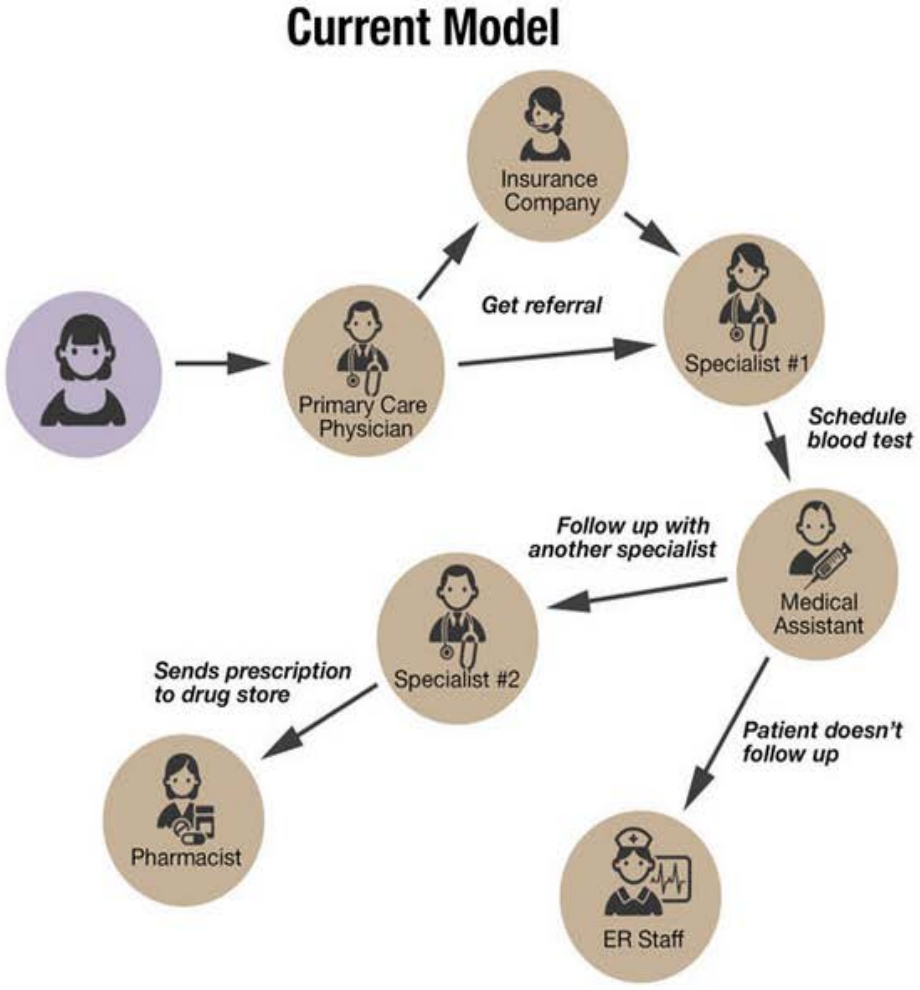
Rethinking Primary Care

Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:



UCSF

Source: [UCSF Center for Excellence in Primary Care](#).

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Lots of expectations to manage….

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	**Midpoint**	**High**	**Low**	**Midpoint**	**High**
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

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Delivery reform:

Growing evidence to support that it works

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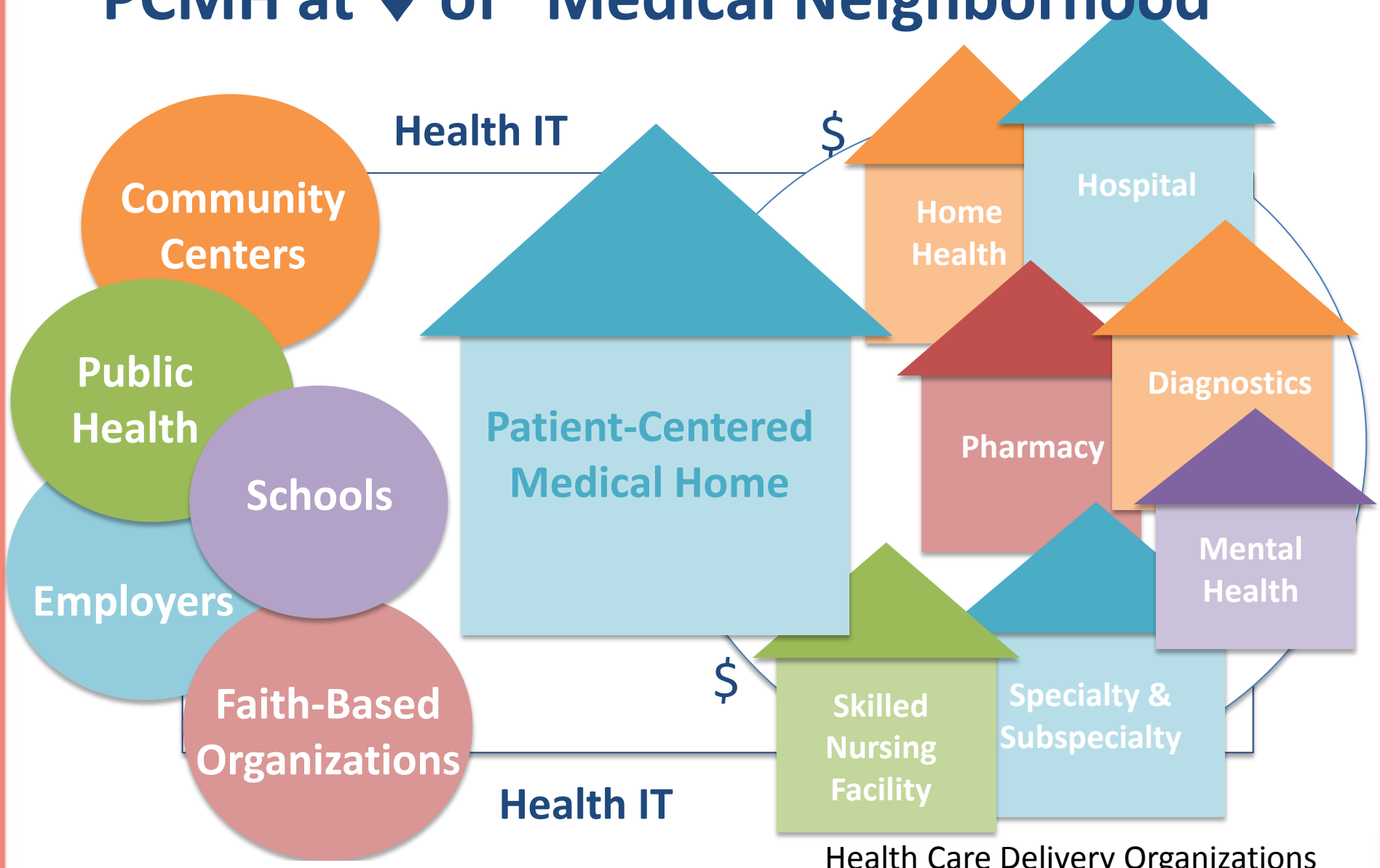
PCMH at ♥ of "Medical Neighborhood"



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PCMH as hub for "medical neighborhood" and broader community

PCMHs serves as central "hub" for all health and social support services to achieve care coordination

Clinical partners

- Specialists
- Hospitals
- Home health
- Long term care
- Clinical providers

Non-clinical partners

- Community centers
- Faith-based organizations
- Schools
- Employers
- Public health agencies
- YMCAS
- Meals on Wheels

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PCMH enhances ability to identify and manage high-risk, high need populations

- Risk stratification and diligent monitoring for all patients
- Track care plans and medication adherence
- Proactive outreach from care team with collaboration among specialists and primary care
- Patient engagement and activation

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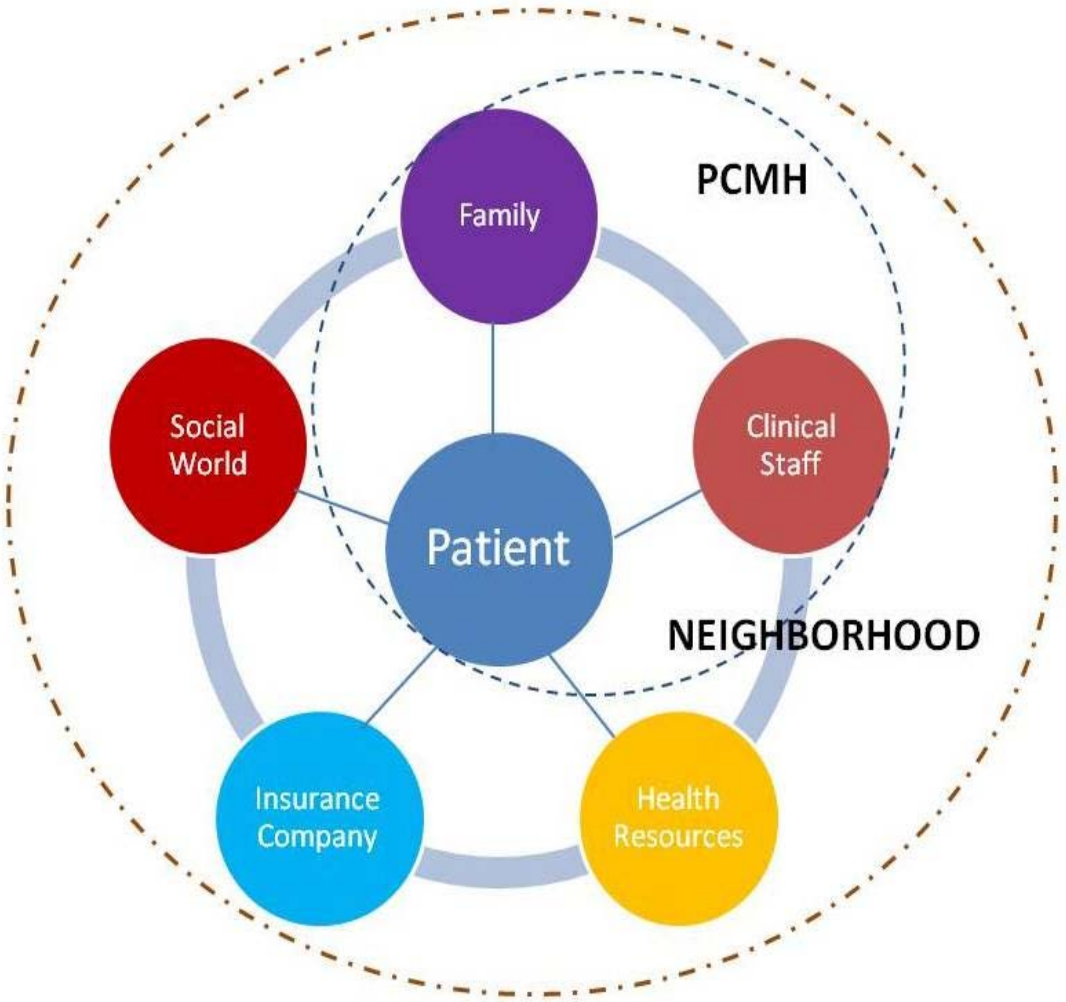
PCMH uses diverse empowered care teams

- Care coordinators
- Patient navigators
- Health coaches
- Peer support
- Care managers
- Behavioral health/mental health
- Community supports and social workers
- Pharmacists
- Patients, families & Caregivers



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PCMH facilitates care that is documented and shared electronically

- Shared with **patients** through electronic records, portals, mobile apps, email
  - Includes patient-generated data
- Shared across **providers and institutions** through health information exchanges
- Shared across **public and private** payers

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PCMH supports Improved access to care & better patient experience

- 24/7 access to care team (phone or e-consults with nurses, etc.)
- Alternatives to traditional face-to-face visits, including telemedicine, group visits, e-consults, peer support
- Access to electronic health records and patient portals

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PCMH includes patients, families & caregivers as part of care team

- Consider experience of care from the patient's perspective – and includes families & caregivers
- Patients with multiple chronic conditions (and/or their caregivers) often in best position to advise care team on challenges/opportunities to improve care
- Through their stories, patients can energize and encourage team to promote compassionate care

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PCMH includes patients, families & caregivers in practice transformation

- Invite patients/caregivers into quality improvement efforts from the very beginning
- Invite patients/caregivers that represent the larger patient population (i.e. ethnicity, culture)
- Invite patients/caregivers with experience managing their own condition
- Provide compensation for patients/caregiver advisors
- Invite more than one patient, family, caregiver

NEED CITATION – GET THEM TO BEV'S TOOLKIT

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Need to Integrate Behavioral Health into Primary Care

Consultative Model

- Psychiatrist/psychologist/social worker (behavioral /mental health expert) sees patients in consultation in behavioral health setting

Co-located Model

- Behavioral/mental health expert sees patients in primary care setting

Collaborative (or Embedded) Model

- Behavioral/mental health expert provides caseload consultation about primary care patients; works closely with primary care team

Source: http://uwaims.org

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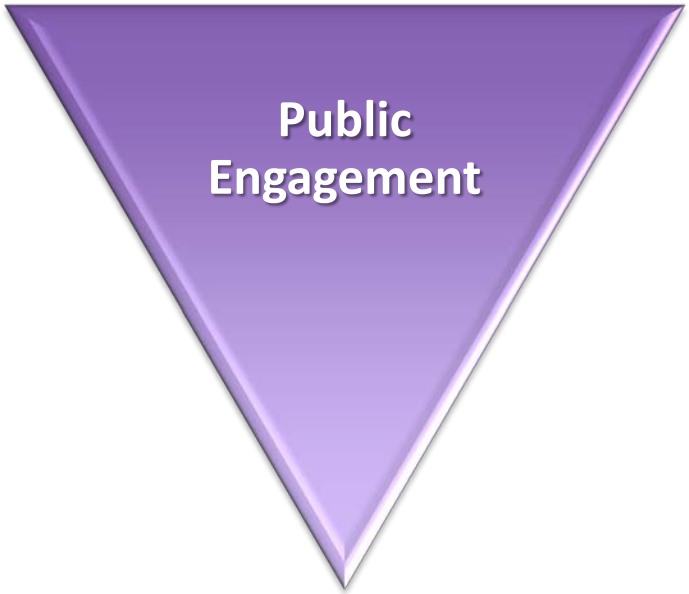
Public Engagement:

Patients, Families & Caregivers, and Consumers must drive demand for the model



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Payment Reforms:

Necessary to sustain the model (and the progress made)

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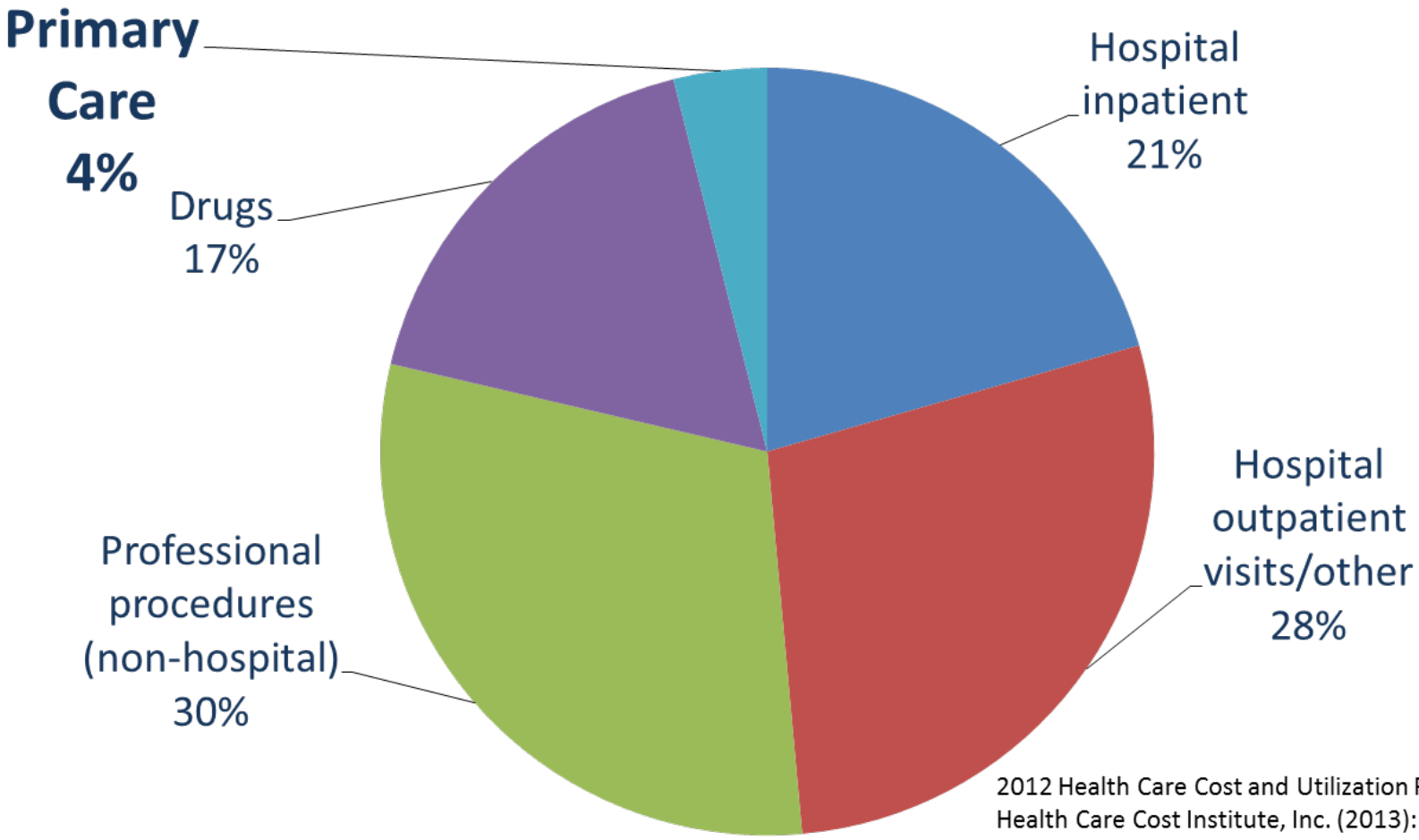
Primary Care Remains Undervalued



2012 Health Care Cost and Utilization Report. "
Health Care Cost Institute, Inc. (2013): Table A1 [Inte
Washington, DC: HCCI; 2013 Sept
http://www.healthcostinstitute.org/

U.S. per-capita health spending, 2012 (under 65 with employer-sponsored health insurance)

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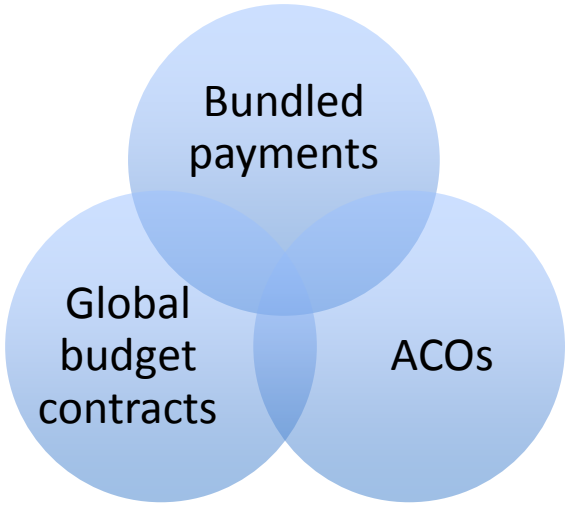
Emerging Payment Reform Trends



Volume-based reimbursement

Value-based reimbursement

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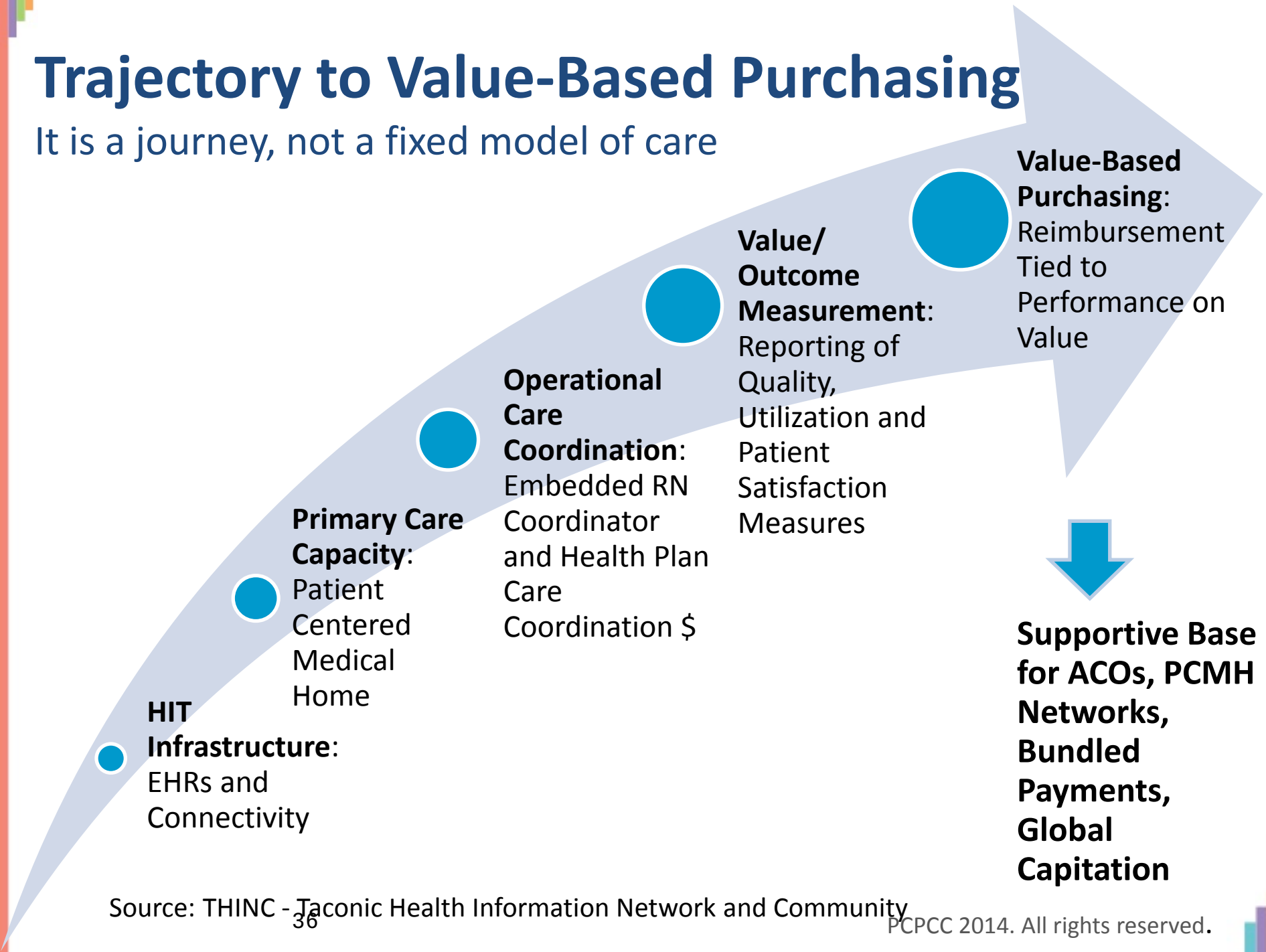
Trajectory to Value-Based Purchasing

It is a journey, not a fixed model of care



Source: THINC - Taconic Health Information Network and Community

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The payment reform imperative

- Increasing % spend on primary care and payment reform is integral to the success of the model
- In fee-for-service (FFS), many PCMH strategies and care processes are rarely/poorly reimbursed (ie. team based care, care coordination, phone/e-visits)
- Many PCMH practices paid through FFS component coupled with care management payment (per member per month – PMPM)
- Growing number including: shared savings, bundled payments, partial/full capitation

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Multi-payer payment reforms key to health system transformation

Many states are convening private and public payers and using uniform set of payment & quality metrics to provide needed alignment:

- State/local government used as convening entity (to mitigate antitrust concerns and provide participation of numerous stakeholders)
- Recognizes differences in various markets and encourages local collaboration
- Data from early evaluations trending positive
- Funding from Comprehensive Primary Care (CPC) Initiative & Multi-payer Advanced Primary Care Practice (MAPCP)

Dulsy Watkins (2014) Milbank Memorial Fund

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CMS Innovations 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

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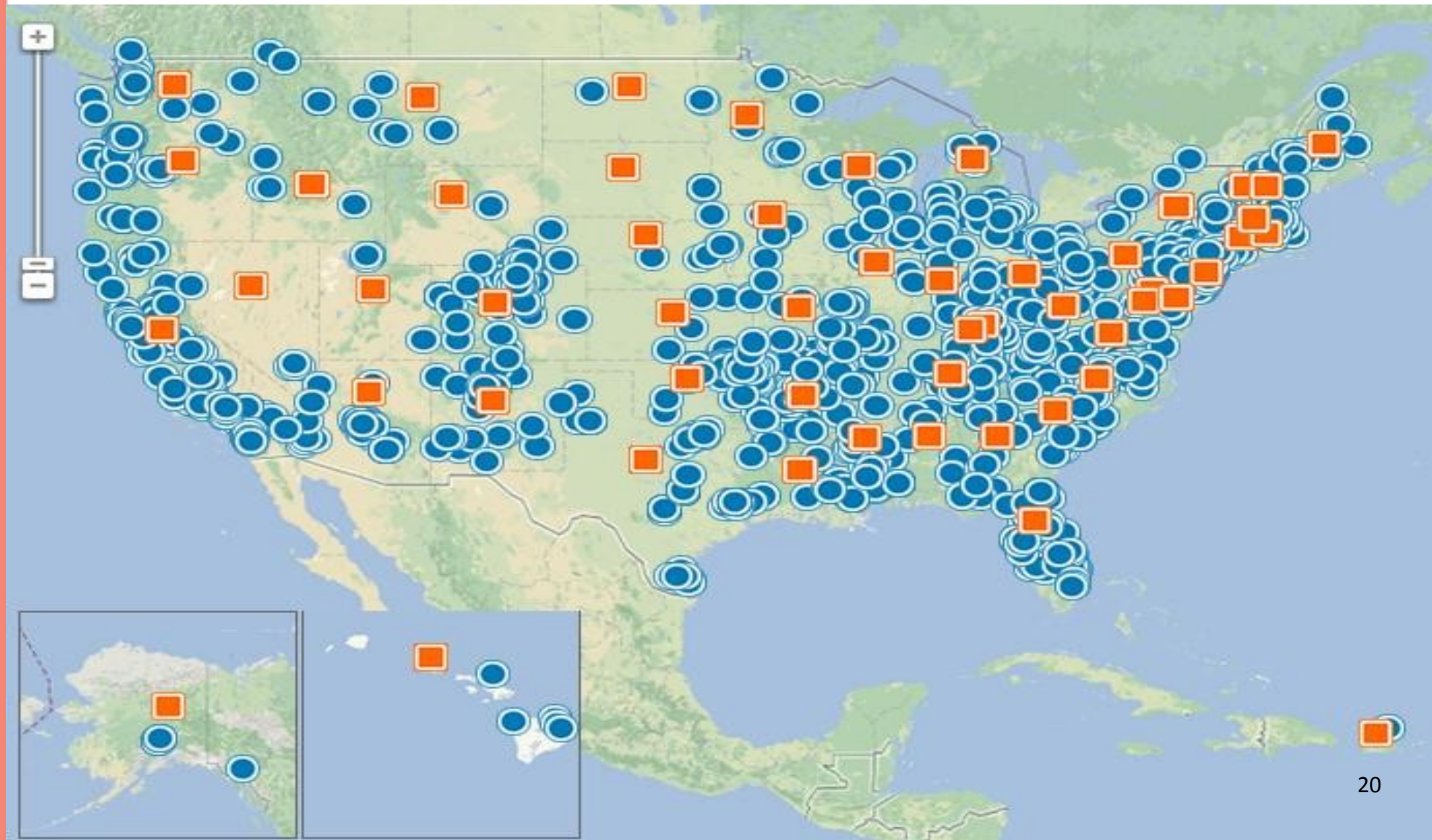
Innovation is happening broadly across the country



Need to change "Supply" and "Demand"

"Supply side" reforms

Reimbursement changes that impact health care delivery:

- Increased payment for providers who adopt PCMH model
- Increased use of shared savings , bundled payments, capitated payments
- Alignment across all payers through multi-payer or all-payer initiatives

"Demand side" reforms

Reimbursement changes that impact consumers and employers:

- Consumers pay less in premiums/copays to use higher-value, PCMH services
- Limit co-pays for wellness visits/primary care
- Use of tiered pharmacy benefits that encourage the use of cost effective prescriptions (including generics)
- Improve consumer understanding of the PCMH model and primary care to better manage health

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Extra Slides

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

Nielsen, M., Olayiwola, J.N., Grundy, P., Grumbach, K. (2014). The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013. Patient Centered Primary Care Collaborative, http://www.pcpcc.org/resource/medical-homes-impact-cost-quality.

For real-time program and outcome updates, visit PCPCC's Primary Care Innovations and PCMH Map: http://www.pcpcc.org/initiatives.

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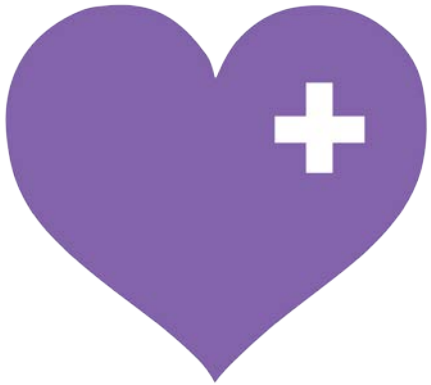
Methods

Reported outcomes are divided into 6 categories:

Cost Savings

Fewer ED / Hospital Visits

Improved Access



Improved Health

Improved Patient/ Clinician Satisfaction

Increased Preventive Services

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Description of Methods

- Examined medical home/PCMH studies published between August 2012 and December 2013
  - Peer-reviewed scholarly articles
  - Industry reports
- Explored relationship between “medical home/PCMH” model of care and Triple Aim outcomes
  - Predictor variable: “Medical home” “or “PCMH”
  - Outcome variables: “Cost” or "utilization”; care experience (access & patient satisfaction); health outcomes (population health & preventive services)
- Resulted in 13 peer reviewed (academic) studies, and 7 industry reports

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Reported Outcomes: Cost Savings

Program	Outcomes	Date Published	Report Type
Anthem BC ACO	$4.7 Million (in 6 months)	June 2014	Industry Report
BCBS Michigan PCMH Program	$26.37 PMPM (2009-2010) $155 million (2008-2011)	July 2013	Peer-Reviewed
Oregon Coordinated Care Organizations (Medicaid)	18-19% reduction in ED visit spending	Nov 2013, June 2014	Industry Report
Vermont Blueprint for Health (Multi-Payer)	Reduced expenditures in 2012 by: • $386 PMPY commercial (ages 1-17) • $586 PMPY commercial (ages 18-64) • $200 PMPY Medicaid (ages 1-17) • $447 PMPY Medicaid (ages 18-64)	Jan 2014	Industry Report
CareFirst BCBS PCMH Program (DC, MD, VA)	$267 million avoided costs (2011-2013)	July 2014	Industry Report
Monarch Healthcare CMS Pioneer ACO (CA)	5.4% reduction in medical costs in 2012 (Medicare)	Jan 2014	Industry Report
Horizon BCBS of New Jersey PCMH Program	$4.5 million savings (ER visits and hospitalizations) 4% lower total cost of care (all pts) 4% lower cost of care (diabetes pts)	July 2014	Industry Report
Independence BC PCMH Program (PA)	Total cost savings for high risk groups: 7.9% and 11.2% (2010, 2009)	March 2014	Peer-Reviewed

Reported Outcomes: Lower ED/Hospital Use

Program	Outcomes	Date Published	Report Type
Aetna PCMH - New York	35% fewer hospital admissions (WESTMED Medical Group, year 1)	June 2014	Industry Report
CareFirst BCBS PCMH Program (DC, MD, VA)	6.4% fewer hospital admissions 8.1% fewer readmissions (all-cause) 11.1% fewer hospital days	July 2014	Industry Report
BCBS Michigan PCMH Program	27.5% lower hospital stays 11.8% lower PC-sensitive ER visits (adults) 9.9% lower ER visits (adults) 14.9% lower ER visits (pediatrics)	July 2014	Industry Report
Missouri Health Homes (Medicaid)	6-8% decrease in ED use 10-13% decrease in hospitalizations	Nov 2013	Industry Report
New York Health Homes (Medicaid)	23% decrease in hospital admissions and ER visits	March 2014	Industry Report
Rhode Island Chronic Care Sustainability Initiative (Multi-Payer)	11.6% fewer ambulatory-sensitive ED visits (2013) Fewer inpatient hospitalizations among more experienced participants (2014)	Nov 2013, May 2014	Peer-Reviewed, Industry Report

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Reported Outcomes: Improved Access

Program	Outcomes	Date Published	Report Type
BCBS Michigan PCMH Program	21.3% lower ER visits (pediatrics) due to appropriate/timely PC	July 2014	Industry Report
Maryland Multi-Payer PCMH Program	Statistically significant improvement in patient access to care (based on survey data)	Feb 2014	Peer-Reviewed
New York Health Homes (Medicaid)	14% increase in primary care visits	March 2014	Industry Report
Oregon Coordinated Care Organizations	18% increase in outpatient PC visits 36% increase in PCMH enrollment	Nov 2013	Industry Report
VA Patient Aligned Care Team (National)	• Increased phone encounters (from 2.7 to 28.8/100 patients/quarter) • Increased use of personal health records (3% to 13% enrolled pts) • Increased electronic messaging to providers (.01% to 2.3% pts/qtr) • Increased same day appts ($p<.01$) • Increase in patients seen within 7 days of desired appointment date (85% to 90%, $p<.01$)	July 2013	Peer-Reviewed

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Reported Outcomes: Improved Health

Program	Outcomes	Date Published	Report Type
Anthem BC ACO (CA)	Increase in meeting quality measures: • 7.5% LDL (diabetes) • 3.8% in cholesterol management for heart disease patients	June 2014	Industry Report
CareFirst PCMH Program (DC, MD, VA)	• 3.7% higher quality scores for panels receiving incentives • 9.3% higher quality scores for PCMH panels (2011-2012)	June 2013	Industry Report
Horizon BCBS NJ PCMH Program	• 14% higher rate in improved diabetes control • 12% higher rate in cholesterol management	July 2014	Industry Report
South Central Pennsylvania Alliance	Improved blood pressure control from 67% in 2010 to 79% in 2013 (East Berlin Family Medicine practice)	June 2014	Industry Report
Fresno PCMH Initiative (CA-AFP)	50% increase in diabetes patients with controlled blood sugar after 1-yr pilot	Feb 2014	Industry Report
Primary Care Information Project (NY Medicaid)	Outperformed non-PCMH practices on BD control in hypertension/ diabetes patients, and smoking cessation intervention measures	June 2014	Peer-Reviewed

Reported Outcomes: Improved Patient/Clinician Satisfaction

Program	Outcomes	Date Published	Report Type
BCBS Michigan PCMH Program	3.5% - 5.2% higher adult quality composite score (2009-2010)	2009-2010	Peer-Reviewed
Fresno PCMH Initiative (CA-AFP)	Overall improvement in patient satisfaction	Feb 2014	Industry Report
MGM Resorts Direct Care Health Plan	88% satisfaction rating among members (2013)	Jan 2014	Industry Report
Rhode Island Chronic Care Sustainability Initiative (Multi-Payer)	Practices increased their positive patient experience ratings for: • access to care • communication with care team • office staff responsiveness • shared decision-making • self-management support	May 2014	Industry Report
VA Patient-Aligned Care Team (National)	• Lower staff burnout in PCMH practices (2.29 vs. 2.80, p=.02) • Higher patient satisfaction scores in PCMH practices (9.33 vs. 7.53, p<.001)	June 2014	Peer-Reviewed

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Reported Outcomes: Increased Preventive Services

Program	Outcomes	Date Published	Report Type
Aetna PCMH – New York	Physicians met or exceeded 9/10 targeted goals: cancer screenings, diabetes & heart disease management & screening, (WESTMED Medical Group, year 1)	June 2014	Industry Report
Horizon BCBS NJ PCMH Program	8% higher rate in breast cancer screenings 6% higher rate in colorectal screenings	July 2014	Industry Report
Husky Health PCMH (CT Medicaid)	Children seen in PCMH 10% more likely to receive recommended EPSDT screenings	July 2014	Industry Report
MGM Resorts Direct Care Health Plan	95% participation in annual physicals led to increase in preventive screening rates and diagnosed conditions (2012)	Jan 2014	Industry Report
Oregon Coordinated Care Organizations (Medicaid)	58% increase in children screened for risk of developmental, behavioral, and social delays (2011)	June 2014	Industry Report
South Central Pennsylvania Alliance	Tobacco cessation counseling improved from 36% in 2010 to 86% in 2013 (East Berlin Family Medicine practice)	June 2014	Industry Report
Vermont Blueprint for Health (Multi-Payer)	• Increased screenings for breast and cervical cancer (adult commercial & Medicaid). • Increased adolescent well-care visits (commercial)	Jan 2014	Industry Report

Reported Outcomes: Behavioral Health

Program	Outcomes	Date Published	Report Type
Georgia PCMH University	• Depression screening rate in elderly increased from 11% to 56% (use PQH-2 every visit) • 6% improved rate of tobacco cessation counseling	July 2014	Industry Report
VA Patient-Aligned Care Teams (Integrated BH, 1 full-time BH coordinator at each facility)	• Lower ED use • Lower hospitalization rates • Lower staff burnout • Higher scores of patient satisfaction	June 2014	Peer-Reviewed
Missouri Medicaid Health Home	• 6-8% decrease in ED use • 10-13% decrease in hospital admissions • Cost savings of $52 PMPM	March 2014	Industry Report
New York Medicaid Health Home	• 23% decrease in hospital admissions and ER visits • 14% increase in primary care visits	March 2014	Industry Report
Rhode Island Chronic Care Sustainability Initiative (Multi-Payer)	• Practices met every targeted patient health outcome and show improvement over time (e.g., weight management, diabetes, high blood pressure, tobacco cessation)	May 2014	Industry Report

Reported Outcomes: Oral Health

Program	Outcomes	Date Published	Report Type
North Carolina Pediatric and General Dentist (opinion survey)	Awareness of AAPD referral guidelines found to significantly lower relative risk of recommending that physicians wait to refer children without varnish.	2014	Peer-Reviewed
Connecticut Health Enhancement Program (State Employees)	Enrollees receive cost-sharing reductions if commit to two free dental cleanings per year (among others). Program results: • 22.9% fewer monthly ED visits • 75% increase in PC visits • 70% reduction in medical trend growth rate	Jan 2013	Industry Report
Institute for Family Health PCMH Program (Manhattan & Hudson Valley – NY Medicaid)	4 of these program sites offer dental services. Program results: • Reduced mean annual A1c levels (from 10.7% to 8.3%) • Increased access to psychosocial, diabetes education, and primary care services (diabetes patients) • Increased patient outreach services, diabetes education support, and HbA1c monitoring & testing.	May 2013	Peer-Reviewed

PCMH Evaluations: Conclusions and Implications

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Challenges to Evaluation

- Need for uniform metrics that are:
  - Parsimonious; patient-centered; account for total cost of care; address process and outcomes of care; include patient engagement; and address clinician satisfaction
- Need of appropriate methods that recognize:
  - Most PCMH initiatives embrace continuous quality improvement (and are thus “moving targets”)
  - The appropriate balance between internal validity and external relevance to payers and policymakers
  - PCMH recognition/certification still evolving and therefore findings linked to these outcomes may have limitations.

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What does the evidence tell us?

- Collectively, studies are finding greater impacts of PCMH interventions on chronically ill populations (in both public and private settings)
- There is a large variation in the ways in which PCMH is being implemented such as differences in:
  - Team composition
  - Populations
  - Payment Models
- There is a dose-response element to PCMH – the longer the initiative is implement, the more impressive the results (Group Health, Kaiser, numerous state programs)

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Future Direction

- Recommendations for Future Evaluations:
  - Define a common set of metrics
  - Determine key aspects of medical home that are most influential in terms of impacting outcomes of care (not just process)
  - Provide more feedback from patients and clinicians on experiences in care
  - Address total cost of care and parsimonious measures of quality

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The Year in Review:
Case Study Snapshots

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VISIT THE PCMH MAP AT WWW.PCPCC.ORG/INITIATIVES

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Veterans Health Administration Patient Aligned Care Team

National program
5 million patients

PCMH Strategies

- Optimize workflow and coordinate care through use of an interprofessional “teamlet” model
- Enact advanced scheduling, such as same-day appointments
- Add phone consults and group appointments

Nelson, K., et al. (2014). Implementation of the PCMH in the Veterans Health Administration. Associations with Patient Satisfaction, Quality of Care, Staff Burnout, and Hospital and ED Use. JAMA Intern Med. 174(8): 1350-1358.
Hebert, P., et al. (2014). PCMH Initiative Produced Modest Economic Results for Veterans Health Administration, 2010-12. 33(6): 980-987.

Results

- Lower ED use
- Lower hospitalizations for ambulatory care-sensitive conditions

- Lower staff burnout
- Higher scores of patient satisfaction

- Increased primary care visits

- Higher performance on 41 of 48 measures of clinical quality

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BlueCross BlueShield of Michigan PCMH Project

Michigan
3 million patients

PCMH Strategies

- Two-part program: (1) Physician Group Incentive Program and (2) PCMH designation of practices
- Develop patient registries to track and monitor patients' care
- Offer 24-hour patient access to a clinical decision-maker through
  - extended office hours
  - telephone access
  - a linkage to urgent care
- Provide online patient resources that allow for electronic communication and greater patient access to medical information

Results

- 27.5% lower rate hospital stays
- 11.8% lower rate of adult primary care-sensitive ER visits
- 9.9% lower rate adult ER visits
- 14.9% lower rate pediatric ER visits

- 21.3% lower rate pediatric ER visits due to appropriate and timely in-office care

- $26.37 PMPM cost savings (2009-2010)
- $155 million cost savings (2008-2011)

Source: Blue Cross Blue Shield Blue Care Network of Michigan. Press Release. (July 2014). BCBS of Michigan designates more than 1400 physician practices to PCMH program for 2014 program year.

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UPMC Health Plan Medical Home

Pennsylvania
23,390 patients

PCMH Strategies

- Practice-based nurses provide care management
- Create telehealth options for care managers to connect to patients when in-office visits are not possible or necessary
- Offer incentives to payers to enter into PCMH contracts

Results

- 2.6% reduction in total costs
- 160% ROI

- 2.8% fewer inpatient admissions
- 18.3% fewer readmissions
- 5.1% fewer ED visits

- 6.6 percentage point increase in HbA1c testing
- 23.2 percentage point increase in eye exams
- 9.7 percentage point increase in LDL screenings

Rosenberg, C.N., Peele, P., Keyser, D., McAnallen, S., & Holder, D. (2012) Results from a patient-centered medical home pilot at UPMC Health Plan hold lessons for broader adoption of the model. Health Affairs. 31(11).

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CareFirst BlueCross BlueShield (DC, MD, VA)

Mid-Atlantic Region
3.4 million patients

PCMH Strategies

- Use local care coordination teams to track high-risk members
- Create an infrastructure for nursing support, easily-accessible online tools and data, and targeted health programs
- Offer increased reimbursements to physicians based on performance in the program

Results

- $267 million in avoided cost savings (2011-2013) [2]
- 4.7% average savings for primary care panels that received an incentive award[1]

- 3.7% higher quality scores for panels that received incentives[1]
- 9.3% higher quality scores for PCMH panels (2011-2012) [1]

- 6.4% fewer hospital admissions[2]
- 8.1% fewer hospital readmissions for all causes[2]
- 11.1% fewer hospital days[2]

[1]Blue Cross Blue Shield Association. PCMH program trims expected health care costs by $98 million in second year. Press Release, June 2013. [2]Blue Cross Blue Shield Association. PCMH program shows promising quality trends and continued savings on expected costs. Press Release, June 2014.

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Oregon Health Authority Coordinated Care Organizations (CCOs)

Statewide Medicaid Program
600,000 patients

PCMH Strategies

- Establish a primary care infrastructure that includes 450 PCMH practices and clinics
- Increase the use of outpatient care to promote prevention
- Increase well-care visits to adolescents to reduce unnecessary ED visits
- Provide follow-up care to patients within 7 days of being discharged

Results

- 17% reduction in ED visits
- 18-32% fewer ED visits for chronic disease patients (CHF, COPD, asthma)

- 58% increase in children screened for mental/behavioral health risks

- 19% reduction in ED visit spending

- 52% increase in PCMH enrollment
- 11% increase in outpatient primary care visits

Oregon Health Authority. (June 2014). Oregon's Health System Transformation: 2013 Performance Report.

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Resources

Nielsen, M. Olayiwola, J.N., Grundy, P., Grumbach, K. (ed.) Shaljian, M. The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013. Patient-Centered Primary Care Collaborative (2014).

To view the full report, visit:
http://www.pcpcc.org/resource/medical-homes-impact-cost-quality

For real-time program and outcome updates, visit PCPCC's Primary Care Innovations and PCMH Map: http://www.pcpcc.org/initiatives.

Patient-Centered
Primary Care
COLLABORATIVE

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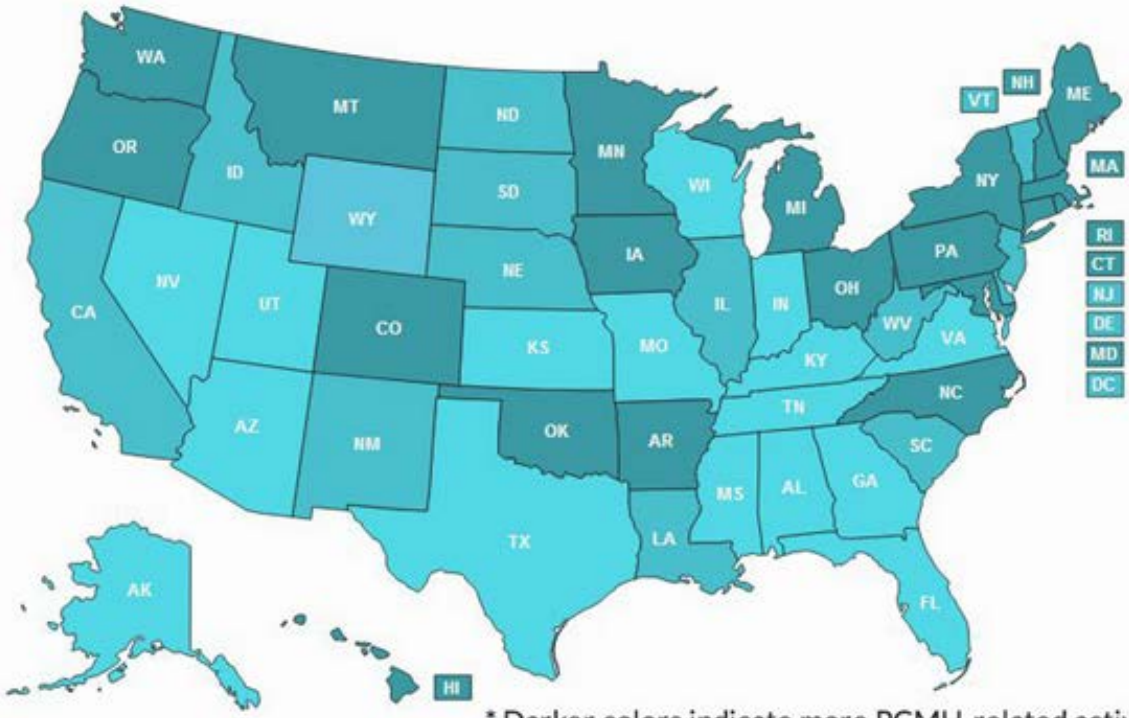
Primary Care Innovations and PCMH Map

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

- National View
- List View
- State View
- FAQ Page

What is a Medical Home?

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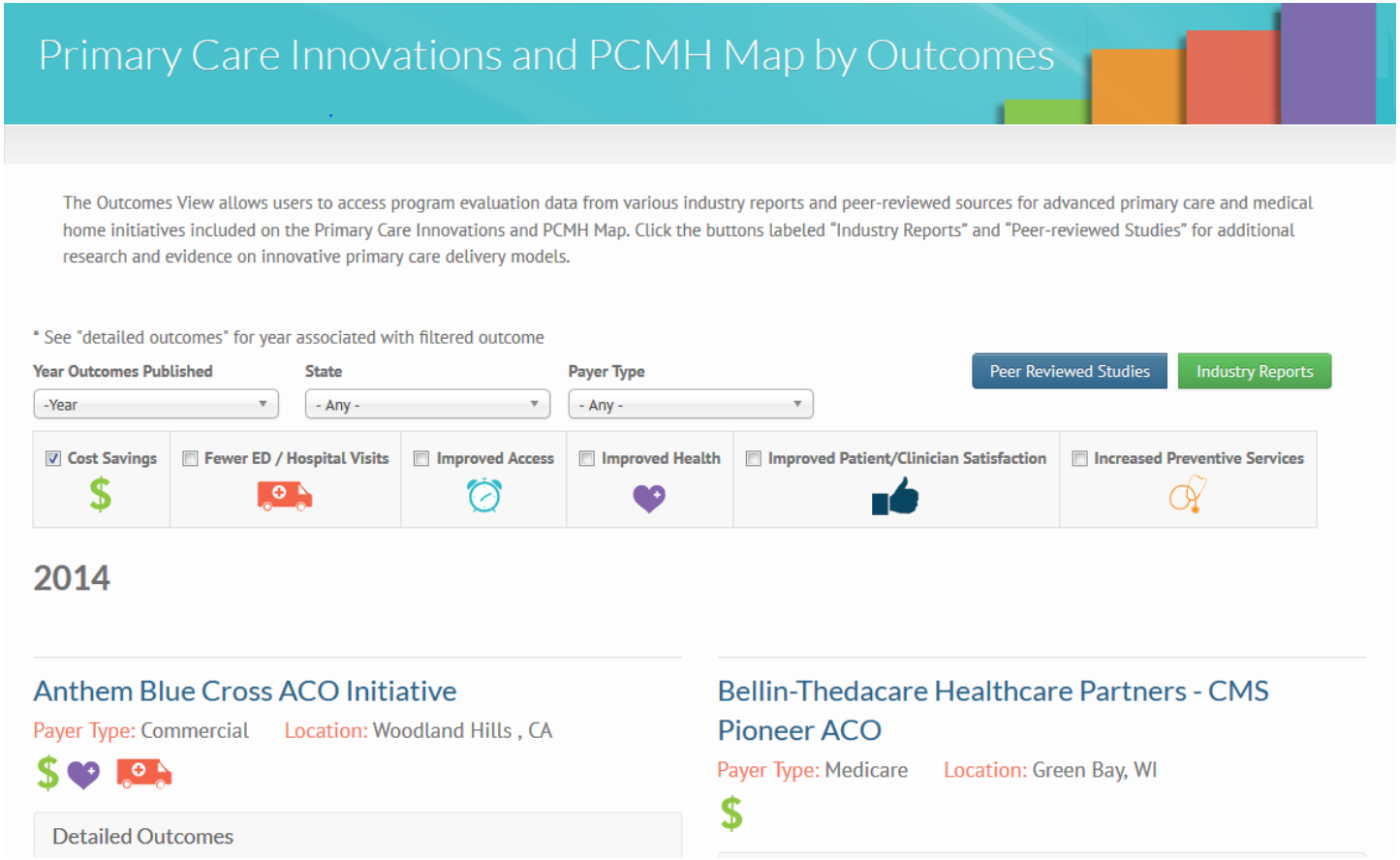
Filter Results by Outcome

Go to the "Outcomes View" for PCPCC's Primary Care Innovations and PCMH Map http://www.pcpcc.org/initiatives/evidence



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