

### Transcript Details

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### Updates from the Patient Centered Primary Care Collaborative

Mark Masselli:

This is Conversations On Healthcare, I'm Mark Masselli.

Margaret Flinter:

And I'm Margaret Flinter.

Mark Masselli:

Well, Margaret, changes are underway in the White House as the president continues to assemble an emergency response team to the Ebola threat in this country. Dr. Karen DeSalvo, a recent guest on this show, is leaving her post as the National Coordinator for Health IT to become Acting Assistant Secretary of Health. She will be reporting to the new Ebola czar recently named by the president.

Margaret Flinter:

Well, Ron Klain was named to that post of czar. He's a Washington insider with significant experience as Chief of Staff for Vice President Biden as well as having served as general counsel for Vice President Al Gore. Critics saying that he didn't have enough direct experience in healthcare or in public health for the position.

Mark Masselli:

That can't be said of Dr. Karen DeSalvo who has a terrific credential and experience. She's an internist with a focus on, she earned her medical degree as well as her master's in public health from Tulane University having taught there as well.

Margaret Flinter:

And Dr. DeSalvo was also the health commissioner for the City of New Orleans, Mark, where she oversaw the transformation of that city's public health system after hurricane Katrina. So she's somebody who understands the complexity of disaster and recovering from disaster and I think her appointment will probably inspire some confidence.

Mark Masselli:

This is a good time to put a team like this in place of the potential threat of such a deadly virus in this country is offering policy makers new experience in the public health arena and a ready response team at the highest level is a good thing for this country's health and security.

Margaret Flinter:

Absolutely, Mark. She was focused on getting the nation moving past the adoption of electronic health records to achieving the goal of meaningful use. She has some very interesting ideas for moving that agenda forward and you can find our interviews with both Dr. DeSalvo and with Dr. Mostashari on our website [chcradio.com](http://chcradio.com). Makes for some interesting listening looking back over recent history.

Mark Masselli:

It really does and our guest today is focusing on improving primary care utilizing a patient centered approach. Dr. Marcy Nielson is the Chief Executive Officer of the Patient Centered Primary Care Collaborative, a consortium of more than a thousand stakeholders dedicated to transforming the healthcare system by building a strong foundation of primary care.

Margaret Flinter:

Well Dr. Nielson's really been an expert and a leader in the development of patient centered medical homes which are increasingly gaining favor across the country as a way to improve overall health by promoting patient centered care in the primary care setting.

Mark Masselli:

Speaking of experts, Laurie Robertson will join us who looks into more false claims spoken about health policy in the public domain, but no matter what the topic you can hear all of our shows by going to [chcradio.com](http://chcradio.com).

Margaret Flinter:

And as always if you have comments please email us at [chcradio@chc1.com](mailto:chcradio@chc1.com) or find us on Facebook or chcradio on Twitter. We love to hear from you.

Now we'll get to our interview with Dr. Marcy Nielson in just a moment.

Mark Masselli:

But first, here's our producer Mary Ann O'Hare with this week's headline news.

Mary Ann O'Hare:

I'm Mary Ann O'Hare with these healthcare headlines. The GOP takeover of both houses of congress bodes ominous for some aspects of the healthcare law. Senator Mitch McConnell, the heir apparent to the majority leader post is already offering prescriptions for repeal of Obamacare which is likely to dominate the senate agenda when they return to Washington.

Medicaid expansion looks unlikely in states like Florida, Wisconsin or Kansas where contested GOP governors won re-election. Governor Rick Scott of Florida, Brownback of Kansas and Walker of Wisconsin vowing continued opposition to the expansion of Medicaid coverage. In Florida alone some 850 thousand residents would gain coverage under such expansion which is covered entirely by the federal government over the first three years of the program.

Meanwhile, there were other healthcare related issues on ballots around the country. Two measures extending personhood to unborn fetuses failed in Colorado and North Dakota. In Arizona, voters as expected, supported a right to try ballot measure that would allow but not require drug makers to provide not yet approved drugs to people with terminal illness. Colorado became the first state with a right to try law earlier this year.

Meanwhile in California, proposition 45 went down in defeat. It would have imposed the same public notice and transparency requirements for health insurance premium rates as voters approved for auto and homeowner insurance in 1988. It would also have given the state's insurance commissioner the right to reject rate hikes deemed excessive. The proposal was fiercely opposed by the health insurance industry which raised 50 million dollars to fight it. But proposition 46 would also have made California the first state to require random drug and alcohol testing for physicians. That part of the proposal prompted many editorial boards to turn against it.

Berkeley, California has become the first municipality to pass a tax on soda and sugary drinks. Consumption of the high fructose corn syrup laden beverages linked directly to increased obesity and diabetes.

When Brittany Maynard went public with her plan to end her life with dignity rather than succumb to the final ravages of aggressive brain cancer it sparked a long overdue national debate. The California woman who moved to Oregon where death with dignity laws allow physicians to prescribe life ending medications for the terminally ill. Her passing has left a vibrant dialogue in its wake. The Death with Dignity national center in Oregon and Compassion in Choices organizations seeing a huge influx of interest for information on the topic. Currently only a handful of states allow the practice.

I'm Mary Ann O'Hare with these healthcare headlines.

Mark Masselli:

We're speaking today with Dr. Marcy Nielson, Chief Executive Officer at the Patient Centered Primary Care Collaborative, a consortium of stakeholders dedicated to transforming the healthcare system by building a strong foundation of primary care. Prior to that, Dr. Nielson served as vice chancellor for public affairs at the University of Kansas School of Medicine Department of Health Policy and Management. She serves on numerous boards including the American Board of Family Medicine and was a committee member of the IOM's Healthy People 20 20 initiative. She earned her master's in public health at George Washington University and her PhD in health policy from Johns Hopkins School of Public Health. Dr. Nielson, welcome to conversations on healthcare.

Dr. Marcy Nielson:

Thank you so much for having me.

Mark Masselli:

Your collaboration is a consortium of over a thousand members, it's a really big tent that you have. Hospitals, provider groups, consumer groups, labor unions, policy organizations, all dedicated to the notion that patient centered medical home is the cornerstone of a successful health industry transformation. You've said that the patient centered medical home is not a place but rather is a kind of care

and bolstering primary care is a way to managing population health and reverse the trends of costly care and poor outcomes. We're hearing the term more and more lately as PCMH model is central to the recent health transformation. Can you tell our listeners more about the key components and objectives of the patient centered medical home?

Dr. Marcy Nielson:

Absolutely. The patient centered medical home is one very important part of health system transformation, which is really the goal here. It's really what we're talking about. And I want to start with pointing out that the patient centered medical home, as you point out, is really a model of care. That model of care is focused largely on primary care operating within a well-functioning medical neighborhood so all of the other entities that help deliver health care services. It is foundational to overall delivery reform.

Primary care, most folks don't realize, is just five to six percent of what we spend on healthcare all together. But it drives about 50 to 60 percent of all healthcare decisions because primary care physicians and nurse practitioners send folks to specialty care, send folks to hospitals, make decisions in partnership with patients about follow up care. So primary care really is the heart of where transformation can happen.

Margaret Flinter:

Well, Marcy you point out how vital it is that the patient actually be at the center of this patient centered medical home model, as the name would imply, but that we're still not there yet. We are doing it in the context of a system that really was probably developed more to support providers in how they were delivering care than to put the patient at the center of it. One of the points that you make is that the average patient awake five thousand hours a year may be with their provider four hours a year.

So this space in between the visits, all of that additional time, is when patients need to be activated and engaged and empowered around their own healthcare. You said for the PCMH model to work that providers really need to think about improving care delivery in five key areas to help patients, to entice them to be better consumers and masters of their own healthcare. What are those five key areas that providers need to be focused on?

Dr. Marcy Nielson:

Sure. And the five key areas relate directly back to how we define a well-functioning, patient centered medical home. So starting first with this notion of patient centeredness and what that means. It's more than just thinking about a patient as a person who needs healthcare services. It's really about a partnership and a relationship between that person and their family, together with their clinician making decisions about health that respect that patient's wants and their needs and their preferences.

Making sure that the patients have all the education and tools that they need to make good decisions on their own behalf and then that we partner with them to be part of health system change. So they're not just passive recipients of an improved healthcare system but they have a seat at the table when we're making decisions about how to reform a medical practice or a hospital. And that's a fairly new concept. So patient centeredness is first and it's key.

The second piece of this is comprehensive. First of all, a comprehensive set of providers who, working with that patient, determining what that patient needs, can give the patient all of those services at the right time and the right place and, quite frankly, for the right price. Sometimes we don't need the physician to spend an hour with the patient talking about diabetes education, but maybe it would be better to have a health educator. So comprehensiveness is a comprehensive team of folks that are focused on the comprehensive needs of the patient.

What I mean by that is we so often think of individuals as disease states or diagnosis when we are healthcare providers. It's how we've been trained to think about healthcare. What we ought to be doing is switching that paradigm and thinking about comprehensive whole person care. People are never just their diseases and the circumstances in which they are trying to live their lives are often far more complicated than yes I've got diabetes and I need to watch my blood sugar. That diabetes is actually also impacting my happiness, so I'm depressed. Maybe my diabetes is impacting my ability to work well. So comprehensiveness is second.

The third piece of this is accessibility. We've built a healthcare system around what's most convenient for the provision of services versus building a health system that's both convenient and practical for patients. It includes things like 24/7 access. We know that lots of patients prefer to do things online whether that's scheduling, whether that's following up with a lab test, whether that's communicating with their providers in an email format and there are technologies that allow primary care practices to do this well. Two final things then is care coordination.

We know when patients are well and health convenience is really important. But when you're not well, when you've got a chronic illness, what a primary care practice can do when it's a patient centered medical home is put care coordination at the top of their priority list making certain that that patient knows who they need to connect with in the health system and how, and really helping quarterback that process. The patient is very clear about what their expectations are but that the health system is really designed to work around them

and the primary care provider is helping to coordinate all that care.

And then finally, we have long had a healthcare system that's committed to quality and safety but in many ways there are significant gaps. We don't share information nearly as widely as we ought to. We're still struggling with interoperability and so we need technology and tools that support information sharing across healthcare providers, but also with that patient so that they can help drive their own care.

Mark Masselli:

I think this is where maybe there's a little confusion in the public's mind because you also have the concept of medical neighborhoods and also accountable care organizations. I think our listeners need to know how they all come together. We've had some great initiatives that have spun off the Affordable Care Act but help our listeners understand how the patient centered medical home, the medical neighborhood or the accountable care organizations matter in their life.

Dr. Marcy Nielson:

Yes, it is true. We have an alphabet soup of terms that aren't easily understood by patients and their families. There is a misunderstanding that somehow medical homes, PCMHs, are somehow different or in competition with accountable care organizations or ACOs. And really one is an extension of the other. If most folks get the majority of their health care in a primary care setting, that's a patient centered medical home. When those patient centered medical homes partner together with specialists and hospitals, pharmacists, home health, the list goes on and on, now you're talking about a medical neighborhood. And when they have a contractual relationship with one another so that they've decided together as a team of healthcare providers we're going to be responsible for a population's health, now that's called an accountable care organization.

As I said, primary care is just five percent of our total spending. So if we're really focused on health system transformation, we've got to think about the partnership between primary care and specialty care and the last piece, most folks aren't in the health care system or in a clinician's office most of their waking hours. So who else needs to be at the table partnering with the primary care when we think about keeping folks as healthy as possible? And we've done years and years of research on the social determinants of health.

We know that the kinds of things that impact health include employment, access to healthy foods and transportation. But the other folks who really are part of this overall medical neighborhood are public health schools, employers, faith based organizations, new members of the PCPCC include the YMCAs, Meals on Wheels, The American Heart Association. Healthcare is not synonymous with health. We've got to be focused on our overall health.

Margaret Flinter:

Well, Marcy, I'm so glad to hear you make that emphasis. But I am going to dive back within the patient centered medical home. We're certainly seeing increasing awareness among policymakers, I think this is kind of getting back on the agenda in Washington as well that access to such vital services as behavioral health is an essential part of being able to respond to all of the needs of patients. But how do we move forward with advancing this integration more broadly across the entire primary care system?

Dr. Marcy Nielson:

There was a paper that came out last week in an important journal that pointed to the accountable care organizations and how many of them are really starting to embrace behavioral health as part of overall healthcare delivery. The connection between behavioral health and physical health issues is huge. People who are depressed are far more likely to suffer from other chronic diseases. So the connection is part of what they have to manage in their everyday life but we've delivered a healthcare system to them that pays for the services separately. So often there isn't a good working relationship between those two systems because the payment system is broken and our care is, unfortunately, so fragmented. First, we need to educate starting with the patient. They need to understand that they're feeling poorly from a physical health perspective impacts their mental health and their mental health status impacts their ability to take good care of themselves.

The second thing we need to do is we need to start creating a system for that integration to take place, so we need to better equip the primary care practices to integrate behavioral health. But more and more we're seeing behavioral health specialists actually located together with primary care, so they're part of an overall healthcare system that is integrated and so my office as a behavioral health specialist might be right down the hallway from a primary care specialist. That can offer lots of benefits in terms of really trying to address the problem of stigma. We still struggle with folks who need mental health services.

There's a stigma attached to that that is important for us to grapple with. And then a final model of care is terrifically promising with lots of research to support it is when you literally embed folks from the behavioral health system into primary care. So it's not that I have to walk you down the hallway to see the behavioral health specialist but that behavioral health specialist is right on my team and I work with them. Each and every morning we huddle and go through our list of patients and recognize that maybe some of the patients that are

really struggling with some of their chronic illness actually could use some mental health or behavioral health services as well.

The key here is we've got to be able to pay for that. Community health centers like your have been doing this for decades and have much to teach the rest of the health system. And the Affordable Care Act provides us with some new real requirements around behavioral healthcare. Paying for pilots for us to test the best way to integrate this kind of care.

Mark Masselli:

We're speaking today with Dr. Marcy Nielson Chief Executive Officer at the Patient Centered Primary Care Collaborative, a consortium of stakeholders dedicated to transforming the primary care system by building a strong foundation of primary care. She's also served as executive director of the Kansas Public Health Authority under then Governor Kathleen Sebelius.

Marcy, certainly your former boss was a very key member of the Obama team in passing the Affordable Care Act. And now we're headed into the second phase of open enrollment, hopefully millions more of Americans will sign up for coverage under this program. But tell us, from the perspective of the patient centered primary care collaborative how the health law is living up to its promise and where improvements might be made.

Margaret Flinter:

Well of course the Affordable Care Act, passage of that landmark legislation was the most important thing from a healthcare delivery perspective to happen in really 30 years. Since 1965 with passage of Medicare and Medicaid we've been struggling for those individuals who can't afford health insurance but we're still paying for them because of course they get access to healthcare through emergency departments. And so they're incredibly expensive to treat and we do a poor job of managing chronic illness from an emergency room. We'll see continued improvements with no only enrollment but folks learning to use health insurance. We do recognize that health insurance is just one piece, but those healthcare services, the health delivery side, still need a fair amount of reform. And that's sort of where we come in, and the delivery reform piece is still in an early stage.

The Affordable Care Act invested literally millions of dollars in testing out new models of care that would be more efficient, and most importantly improve healthcare outcomes. And we're just starting to see some early results from those pilots. States and the commercial sector have long been engaged with experimenting and the good news is, we now have commercial sector, patient centered medical homes all across the country. Medicaid was the leader in many ways long before the Affordable Care Act passed in piloting some of these programs.

But of course the nugget that is so hard to crack is all of this is so horrifically complicated for the average American. And we're learning a lot about how to engage consumers, but the most important thing, I think, that we have yet to do is figure out the language and the priorities of the average consumer so that they too are as invested in their health and the communities in which they live create the space for them to be healthy. I am amazed that we would suspect that we would live any differently than we do, when we look at how much we are bombarded with messages about better health on the one hand that are dwarfed by the messages that we get from advertising about food and just the many messages that we've got to balance in our lives that don't lead to healthy behaviors.

So government is one piece of what needs to be resolving our broken health system around healthcare delivery. But it can't make Americans healthy unto itself. We need everybody else at the table and that includes the same folks I mentioned before, folks in the community but certain employers, public health plans and most importantly it includes the consumers themselves.

Margaret Flinter:

We've been speaking today with Dr. Marcy Nielson, Chief Executive Officer at the Patient Centered Primary Care Collaborative, a consortium of stakeholders dedicated to transforming primary care through the development of patient centered medical homes. You can learn more about her work by going to [PCPCC.org](http://PCPCC.org) or follow them on Twitter at [PCPCC](https://twitter.com/PCPCC).

Marcy, thank you so much for joining us on Conversations on Healthcare today.

Dr. Marcy Nielson:

Thank you for having me, we appreciate it.

Mark Masselli:

At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Laurie Robertson is an award winning journalist and managing editor of [FactCheck.org](http://FactCheck.org), a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics.

Laurie, what have you got for us this week?

Laurie Robertson:



We've seen plenty of claims in recent years that the Affordable Care Act is a job killer, and in the final week of the midterm campaigns a house candidate in New Mexico made a version of this claim in a TV add. The add from republican Mike Frise showed a video of his opponent, representative Michelle Lujan Grisham saying that the ACA is a job creator. As she speaks, viewers see the words "between April and October, New Mexico lost more than 20 thousand jobs" implying that the Affordable Care Act was to blame. It wasn't.

The figures are for April through October 2013, not this year, and the losses were not as large as initially reported once they were finalized. Plus, there is evidence that the ACA is creating jobs in New Mexico. The add cites the news report from December 2013 that cited the initial job loss numbers. The article quoted in Expert from the Bureau of Business and Economic Research at the University New Mexico said the government sequestration and uncertainty about the federal government were the reasons for the job decline. New Mexico is particularly vulnerable to federal budget cuts. That same expert told us that the large job loss, 20 thousand, was later revised by the Bureau of Labor Statistics, it actually was less than three thousand.

Perhaps more important, she told us that the ACA this year was adding some jobs in the state's insurance and healthcare sectors. From January to September New Mexico saw an increase of 1500 finance jobs which would include insurance and an increase of 3700 jobs in the education and healthcare sector. Experts have long projected that the ACA may cause a small loss of low wage jobs but a rise in jobs in the healthcare and insurance industries.

That's my fact check for this week. I'm Laurie Robertson, Managing Editor of FactCheck.org.

Margaret Flinter:

FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at [chcradio.com](mailto:chcradio.com), we'll have FactCheck.org's Laurie Robertson check it out for you here on Conversations on Healthcare.

Each week, conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

It's no secret that baby boomers are aging in large numbers and that means that those suffering from age related dementia are on the rise as well. Four million Americans live with Alzheimer's disease and we know that number will double by 2025. Daniel Cohen has devised a tool that is improving the experience for these patients whose quality of life declines along with the loss of brain function.

He wondered, what would happen if you provide iPads for patients in nursing homes that are loaded with their own personal playlist of the songs that they loved when they were younger. In his first pilot program called music and memory, patients in a nursing home were given the iPads with their own personalized song list and the results instantly noticeable. Patients went from being noncommunicative and disengaged to being animated an engaged Patients like Henry, featured in this documentary on the program called Alive Inside.

Male Speaker:

Do you like music?

Henry:

I'm crazy about music. You can play beautiful music, beautiful sounds.

Male Speaker:

What was your favorite music when you were young?

Henry:

I guess Cab Calloway was my number one band, yeah, right.

Male Speaker:

What was your favorite Cab Calloway song?

Henry:

Oh. I'll be home for Christmas, you can count on me...

Margaret Flinter:

Cohen explains one of the theories as to why this program works so well.

Cohen:

The reality is because our memories of music are co-located in the brain with our autobiographical memories, when you play a song that's familiar you're kicking off memories that you had.

Margaret Flinter:

The results from the Music and Memory Program were so impressive that Cohen's personalized iPad program is now being used in 50

nursing homes throughout North America and many more are lining up.

Cohen:

We've done some research and the feedback from the frontline, from the nursing homes and from the staff, is that their ability to provide care is facilitated. And so that allows them to get their job done, to pay attention to all the residents as much as possible. That's been a big win as well.

Margaret Flinter:

A simple, personalized application for a readily available piece of technology that could dramatically impact the quality of dementia patients' lives, now that's a bright idea.

This is Conversations on Healthcare, I'm Margaret Flinter.

Mark Masselli:

And I'm Mark Masselli, peace and health.

Female Speaker:

Conversations on healthcare, broadcast from the campus of WESU at Wesleyan University, streamed live at WESUfm.org and brought to you by the community health center.