

Lessons Learned from the Multi-Payer Comprehensive Primary Care Program in Tulsa, OK

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Primary Care Task Force

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- Dr. Daniel Duffy is the Steven Landgarten Chair in Medical Leadership and Past Dean of the OU School of Community Medicine, Tulsa. He served as Executive Vice President of the American Board of Internal Medicine from 1996 to 2006 where he helped to create the self-administered practice improvement module and lead the physician Maintenance of Certification process. At OU, Dr. Duffy has been instrumental in the development of the School of Community Medicine, the Summer Institute for understanding Community Medicine, a Faculty Academy for developing faculty in community medicine, and a Student Academy which teaches third year students in the skills needed to provide longitudinal care to underserved patients suffering with chronic illness.
- Dr. Duffy was Chair of the Department of Medicine at the University of Oklahoma in Tulsa where he has received multiple awards for teaching, a regent for the American College of Physicians, Chair of the Residency Review Committee in Internal Medicine, and Director and Chair of the MOC Committee of the American Board of Medical Specialists.
- Currently he serves of the board of directors of the Community Service Council of Oklahoma, the Oklahoma Center for Healthcare Improvement, and the MyHealth Access Network – an Oklahoma health information organization. He serves on the field service team of the multi-payer Comprehensive Primary Care Initiative sponsored by CMS innovation center.
- Dan can often be found bike riding on the river trails. Dan and wife Kay have been married for 45 years. They have one adult son and two grandchildren.



Greater Tulsa OK Comprehensive Primary Care Program

- Multi-payer public-private collaboration
- Strengthen primary care
- Start-up payment to coordinate care
- Shared savings

68 66 Practices
270 Providers
43,740 Medicare



BlueCross
BlueShield



oklahoma
health care
authority

CommunityCare

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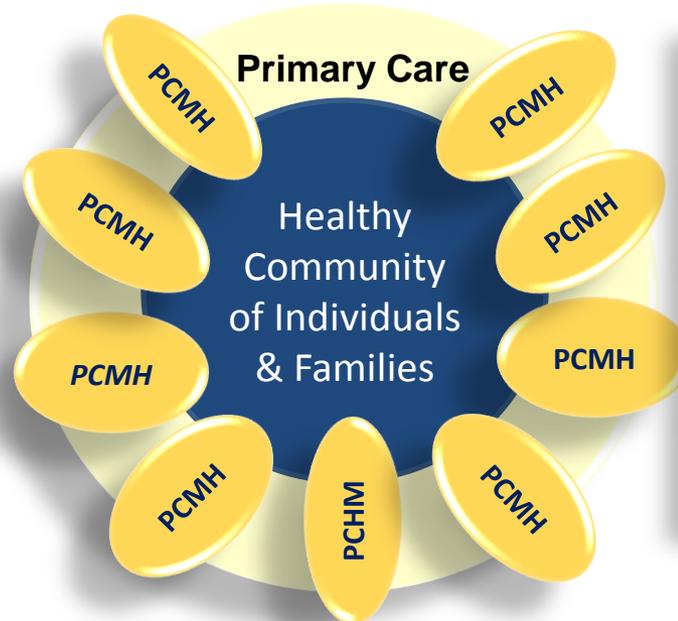


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PCMH Model of Primary Care

Medical Home

- Electronic record
- Care coordination
- 24/7 access
- Shared decisions
- Patient voice



CPC

- Multi-payer standard
- Pay for quality
- Pay for coordination
- Share savings in market

New Workforce and Workflow

- Clinician team mates
- Care managers, health coaches, community health workers
 - Care coordinators and practice workflow
 - Practice data and quality managers

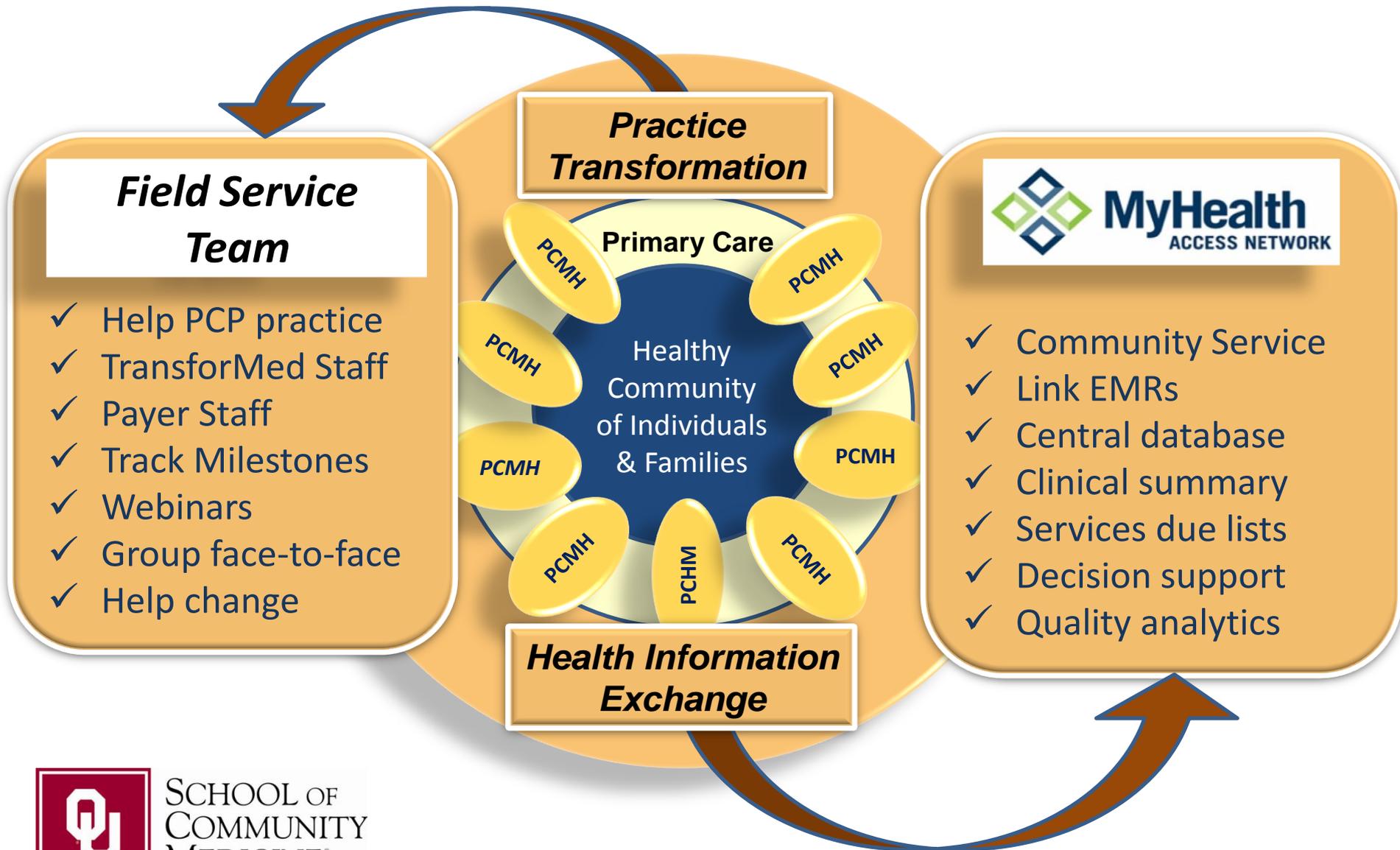


CPC Milestones

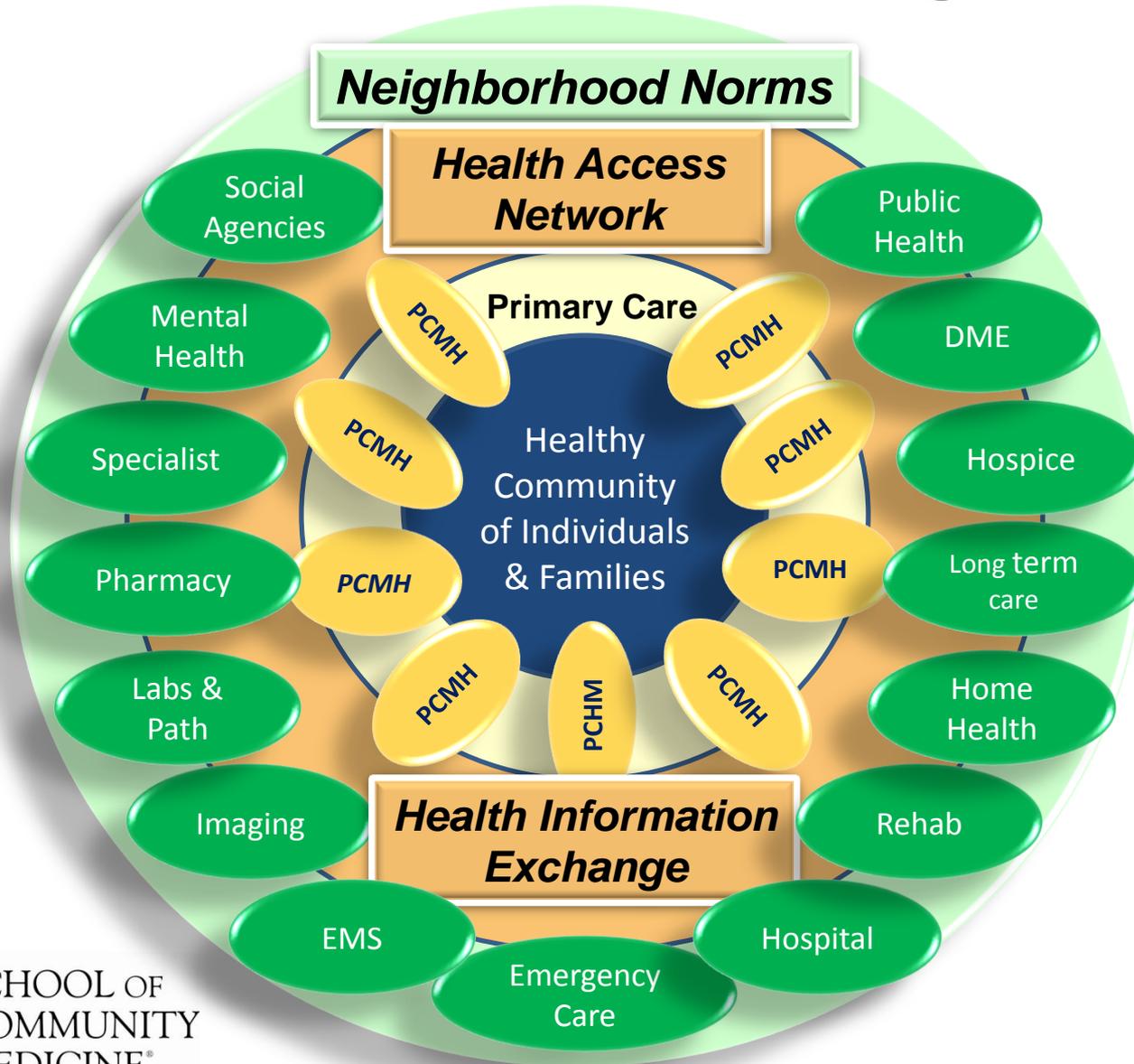
1. **Budget**
2. **Risk Stratification & Care Management**
3. **Access: 24/7 & Asynchronous patient contact**
4. **Patient Experience** - Patient Surveys & input
5. **Quality Improvement** - Report measures
6. **Care Coordination** across Medical Neighborhood: ED/Hospital, agreements
7. **Shared Decision-Making**
8. **Learning Collaborative** Participation
9. **Health Information Technology** - exchange information electronically across practices



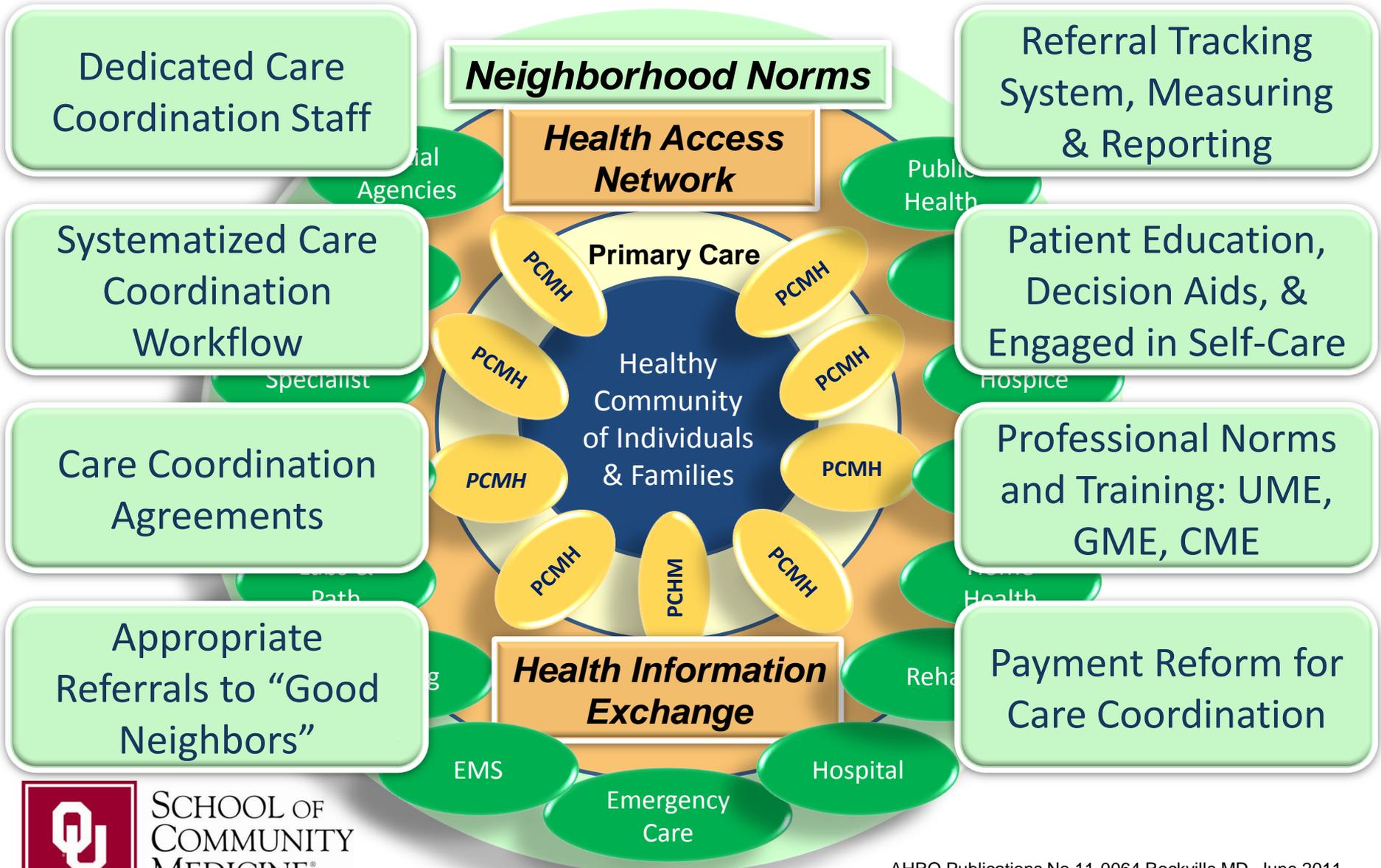
Transformational Services



New Models: Medical Neighborhood

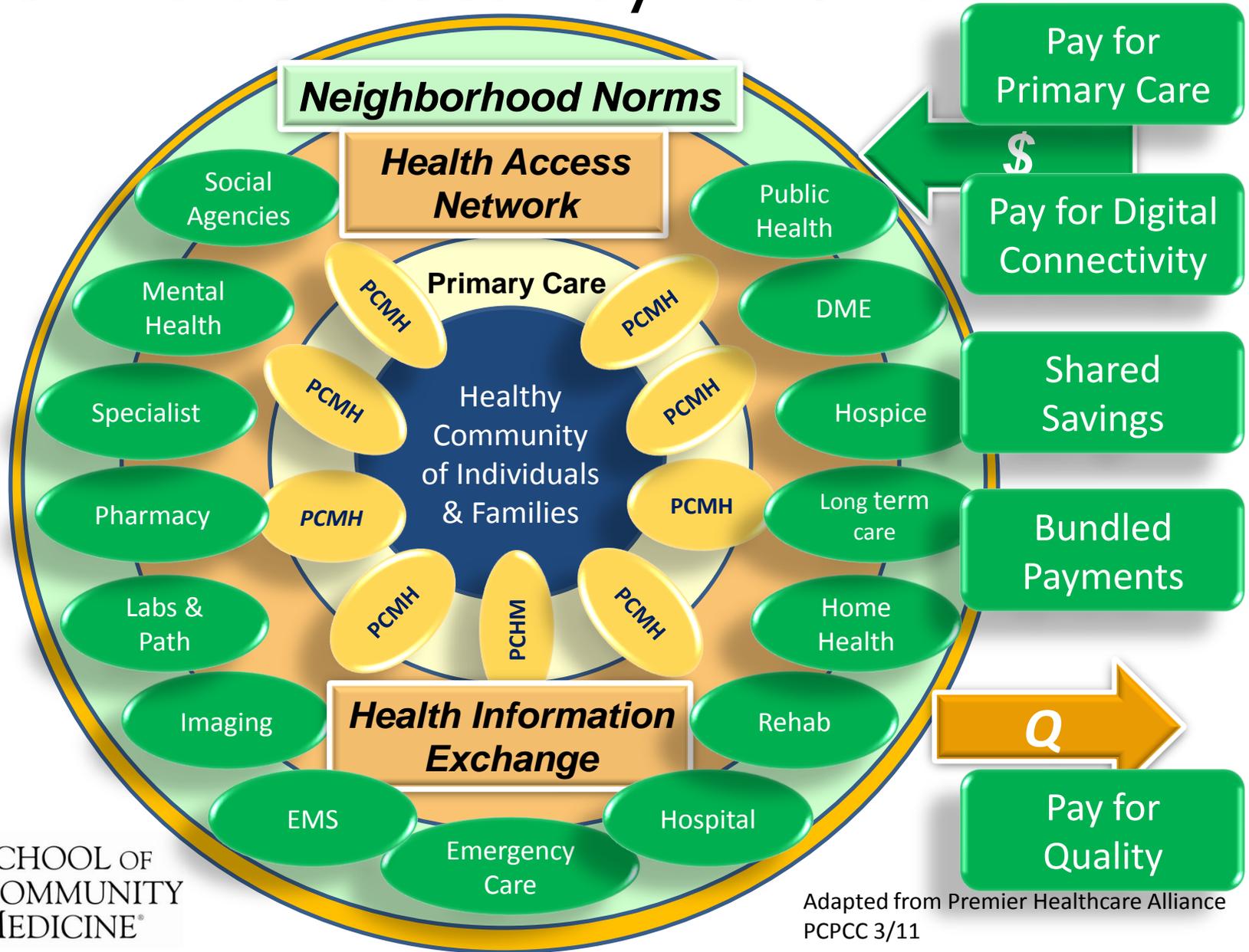


Good Medical Neighbors



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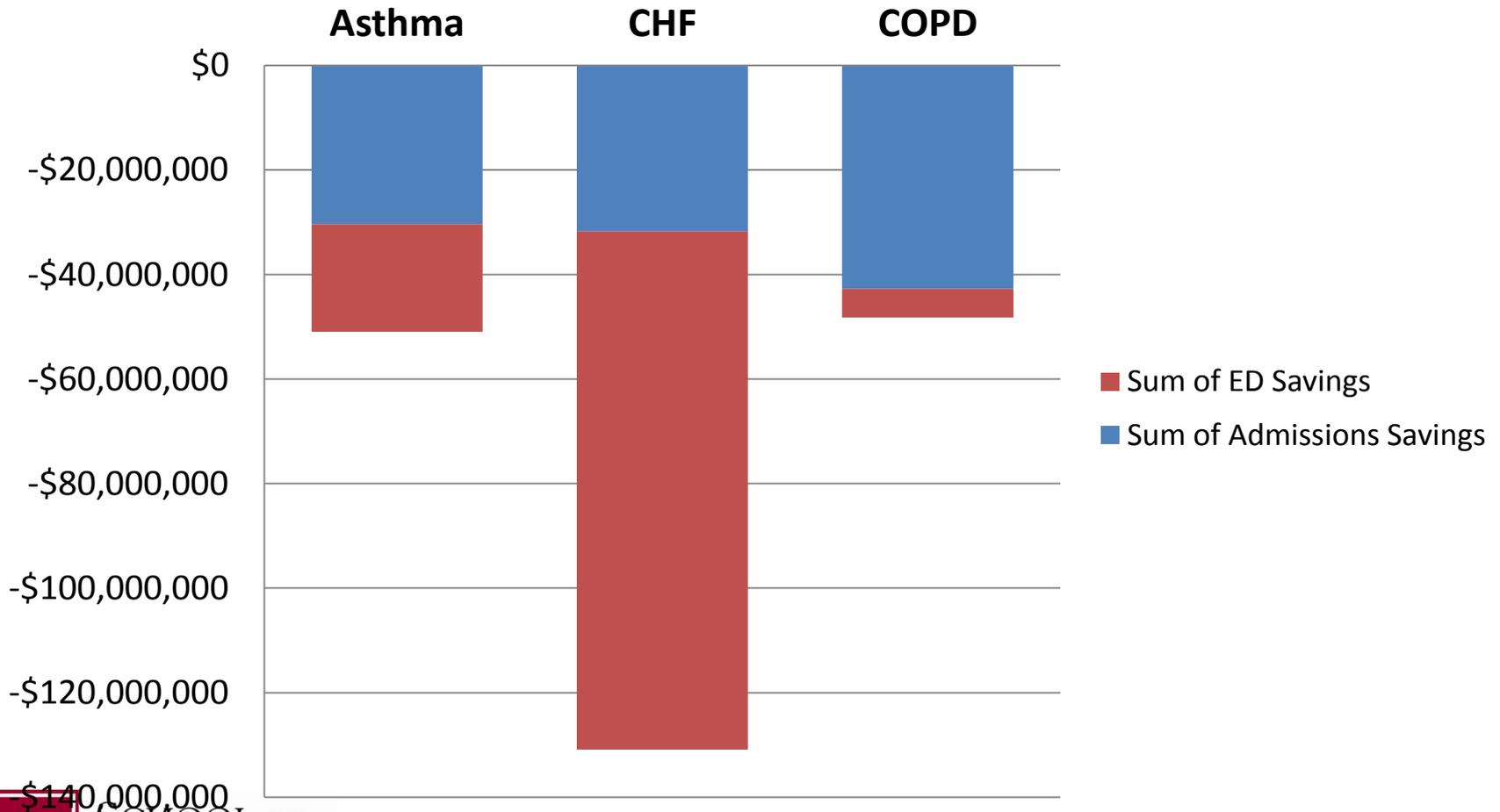
New Value-Based Payment Models



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Adapted from Premier Healthcare Alliance
PCPCC 3/11

Oklahoma: Scaled Savings based on MyHealth measured Utilization Reduction



Oklahoma: Scaled Savings based on MyHealth measured Utilization Reduction

