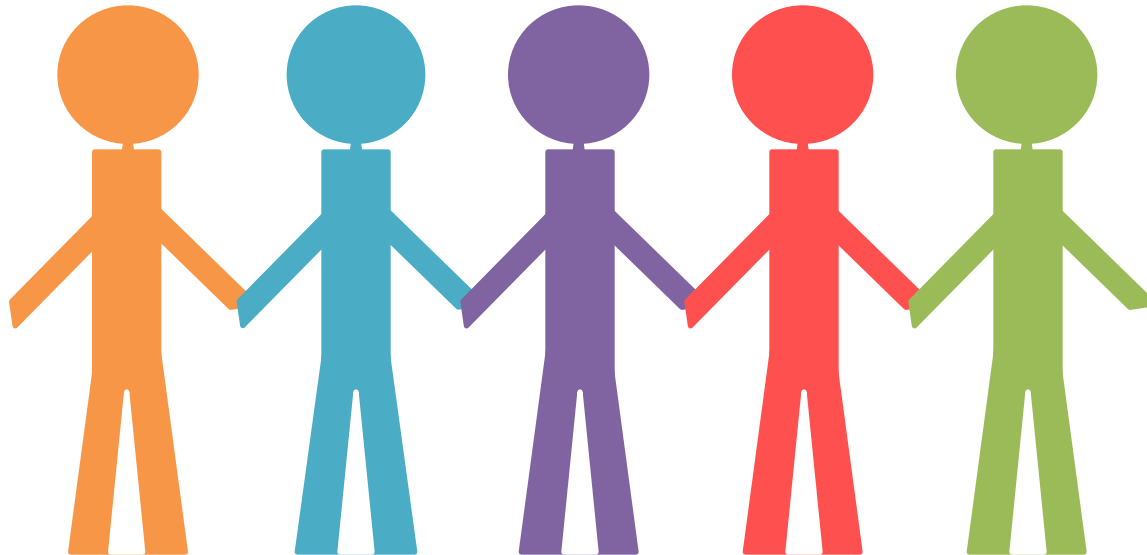


PCPCC's Strategic Plan, 2015-2018

Aligning & Engaging our Stakeholders to Drive Health System Transformation



Welcome & Acknowledgments



Marci Nielsen, PhD, MPH
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Patient-Centered Primary Care Collaborative



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Director, The HALI Project; Family Caregiver

PCPCC Co-Chair, Patients/Families/Consumers Center



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PCPCC Co-Chair, Advocacy & Public Policy Center



Bill Warning, MD, FAAFP

Director, Family Medicine Residency Program, Crozer-Keystone Health System

PCPCC Co-Chair, Care Delivery & Integration Center



Defining the Problem & Finding Solutions

Marci Nielsen



The Current System

- **Patients and Families** view accessing health care services as
 - Intimidating
 - Difficult to navigate
 - Disconnected
 - Expensive, and even unaffordable
- **Primary Care Providers** view delivery of effective yet compassionate care to be
 - Harried
 - Overregulated
 - Undervalued
 - Lacking resources & infrastructure
- **Employers and Policymakers** view health care as
 - Overly costly
 - Lacking clear demonstration of ROI



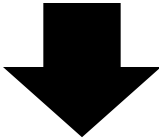
Did you know?

Experts estimate that the **overuse, underuse** and **misuse** of health care resources is roughly **30%** of the total US health care spend

Health System transformation requires...



Delivery Reform



Public Engagement



Payment Reform & Benefit Redesign



Trained Health Work Force



The Need for Better Primary Care

Current Health Care System

Treating Sickness / Episodic

Fragmented Care

Specialty Driven

Isolated Patient Files

Utilization Management

Fee for Service

Payment for Volume

Adversarial

“Everyone For Themselves”

Future with PCMH Implementation

Managing Populations

Collaborative Care

Primary Care Driven

Integrated eHealth Records

Evidence-Based Medicine

Shared Risk/Reward

Payment for Value

Cooperative

Joint Contracting



Solutions point to strengthened Primary Care

Significant problems

Rising healthcare costs
→ \$2.4 trillion
(17% of GDP)

Gaps/variations in
quality and safety

Poor access to primary
care providers

Below-average
population health

↑ Aging population &
chronic disease

... “Experiments” underway

- PCMHs
- ACOs
- EHR/HIE investment
- Disease-management pilots
- Alternative care settings
- Patient engagement
- Care coordination pilots
- Health insurance exchanges
- Top-of-license practice

... Primary care-centric projects have proven results

Across 300+ studies,
better primary care
has proven to increase
quality and curtail
growth of health care
costs

Trajectory to Value-Based Purchasing

It is a journey, not a fixed model of care

HIT Infrastructure:
EHRs and population health management tools

Primary Care Capacity:
PCMH or advanced primary care

Care Coordination:
Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/ Outcome Measurement:
Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing:
Reimbursement tied to performance on value

Alternative Payment Models (APMs): ACOs, PCMH, & other value based arrangements

PCPCC: What We Do

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 (PCMH).

Activities

- **Educate stakeholders and strengthen public policy** that advances and builds support for primary care and the medical home
- **Disseminate results and outcomes** from advanced primary care and PCMH initiatives and clearly communicate their impact on patient experience, quality of care, population health and health care costs
- **Convene health care experts** and patients to promote learning, awareness, and innovation of primary care and the medical home



Health System Transformation

PCPCC's goals achieved through its 5 Stakeholder Centers



Advocacy and Public Policy

- Drives health system reform that incorporates key features of PCMH



Care Delivery and Integration

- Encourages widespread transformation & development of medical neighborhoods



Employers & Purchasers

- Engages employers in redesigning health benefits to promote primary care



Outcomes & Evaluation

- Builds awareness on value of primary care & PCMH using quality and cost evidence



Patients, Families & Consumers

- Assures patients and families are active partners in improving primary care delivery



The Patient-Centered 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



Putting the Pieces Together, What makes a PCMH possible?



Outcomes of Advanced Primary Care

-  Cost Savings
-  Fewer ED/Hospital Visits
-  Improved Access
-  Improved Health
-  Improved Patient/Clinician Satisfaction
-  Increased Preventive Services

Source: Nielsen, M., Gibson, L., Buelt, L., Grundy, P., & Grumbach, K. (2015). **The Patient-Centered Medical Home's Impact on Cost and Quality, Review of Evidence, 2013-2014.** - See more at: <https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality#sthash.iJAvicCb.dpuf>

Mapping Primary Care Innovations

Legend

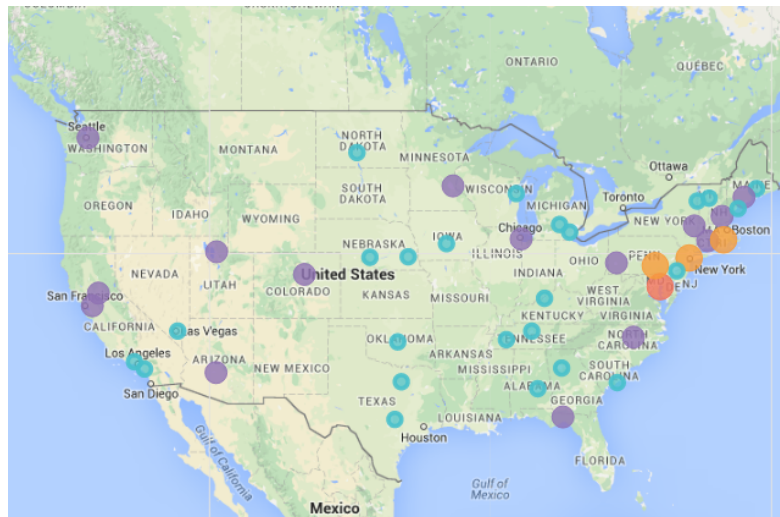
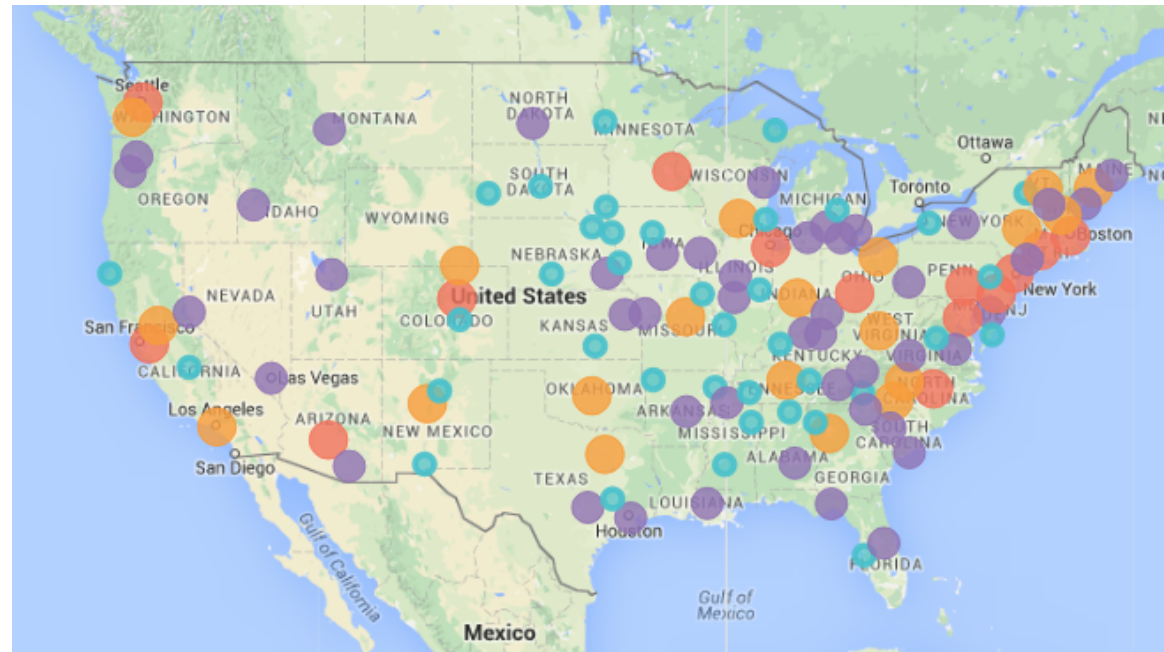
color indicates
number of initiatives

1

2+

5+

8+



Source: **Primary Care Innovations and PCMH Map**. PCPCC. Accessed July 2015. <http://www.pcpcc.org/initiatives>

Map of PCMH initiatives
with reported outcomes

Momentum for PCMH is Growing!

- **Private Sector:** 90+ commercial and not-for-profit health plans are leading PCMH or patient-centered primary care initiatives (e.g., Aetna, Anthem, Blue Cross Blue Shield, Harvard Pilgrim, Kaiser Permanente, UPMC, etc.)
- **Employers:** Dozens of employers offer advanced primary care and PCMH benefits to thousands of employees (e.g., Boeing, Corning IBM, Intel, MGM Resorts, Safeway, Target, Wal-Mart)
- **Public Sector:** Millions receiving patient-centered primary care
 - 44 state Medicaid programs
 - Federal Employee Health Plan
 - Medicare
 - US Military & Veterans Administration
- **Millions more** attributed to PCMH in private practices, community health centers, hospital ambulatory care networks, and independent physician associations

Key Environmental Trends



Testing and adoption of new payment models are expediting care delivery reform (in public & private markets)

Transformation has spread as public and private industries invest more in primary care – and results have been impressive.

Despite growing evidence about the medical home's value and impact, some stakeholders remain uninformed or skeptical.

PCPCC's Strategic Priorities 2015-2018

- 1.** Promote increased primary care investment
- 2.** Promote clinical transformation and integration with the medical neighborhood & communities
- 3.** Promote patient, consumer, employee, & employer engagement
- 4.** Support an interprofessional team-based health workforce





PCPCC's Plan Of Action

- **Dan Lowenstein - Priority 1**
- **Amy Gibson - Priority 2**
- **Brad Thompson - Priority 3**
- **Bill Warning - Priority 4**

Priority 1: Increased Investment in Primary Care



Reduce/control total cost of health care by increasing resources allocated to primary care

Shift from fee-for-service models to value-based / comprehensive primary care payments



Incentivize practices to focus on improving patient experience of care and population health outcomes

How PCPCC Plans to Promote Investments in Primary Care

- Push for **payment reform**: Value over Volume
- **Define primary care** for provider payments
- Develop a primary care **investment measure/indicator**
- Develop common outreach themes to **engage the public**
- Encourage employers to invest in & incentivize **value-based purchasing** that supports primary care



Priority 2: Clinical Transformation and Integration into Medical Neighborhoods & Communities



Promote a shared definition of advanced primary care and the PCMH



Define how to integrate PCMH functions within medical neighborhood, ACOs, and communities – both inside and outside of primary care practices

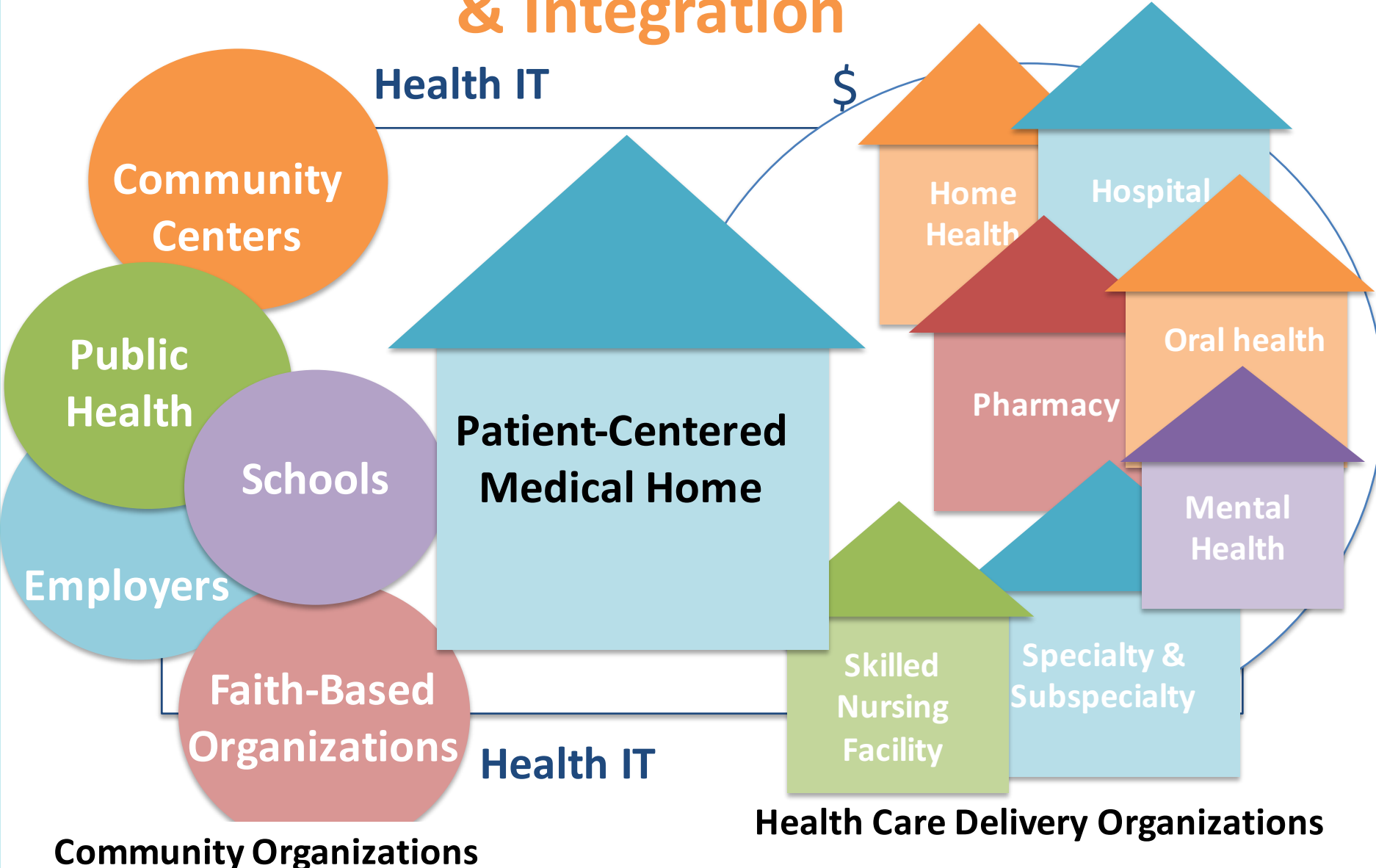


Develop new resources, tools, and supports to help clinicians and communities transform into high-performing, integrated systems of care

How Can We Support Integration into the Medical Neighborhood?

- Convene experts to **improve PCMH standards & accreditation programs** = administrative simplification + patient-centered measures
- Identify **key features of high performing PCMHs and ACOs**
- **Integrate population health** into primary care (behavioral & oral health, HIT infrastructure, medication management, etc.)
- Define & promote **clinic-to-community linkages**

Promoting Clinical Transformation & Integration



Community Organizations

Health Care Delivery Organizations

Priority 3: Increased Engagement of Patients, Consumers, Employees & Employers



Engaging and educating consumers and employees in their own communities – where they live, work, and play



Patients and families/caregivers working alongside clinicians and staff as partners in improving primary care practices



Providing employers and employees with tools/resources to help them to understand the value of advanced primary care models

Let's Engage Patients, Consumers, Employees...and Employers Too!

- Define & support **patient-practice partnerships**
- Develop and promote **meaningful experience metrics** for patients/families/caregivers
- Launch a **public messaging campaign** to educate and engage both employers & their employees in the PCMH movement

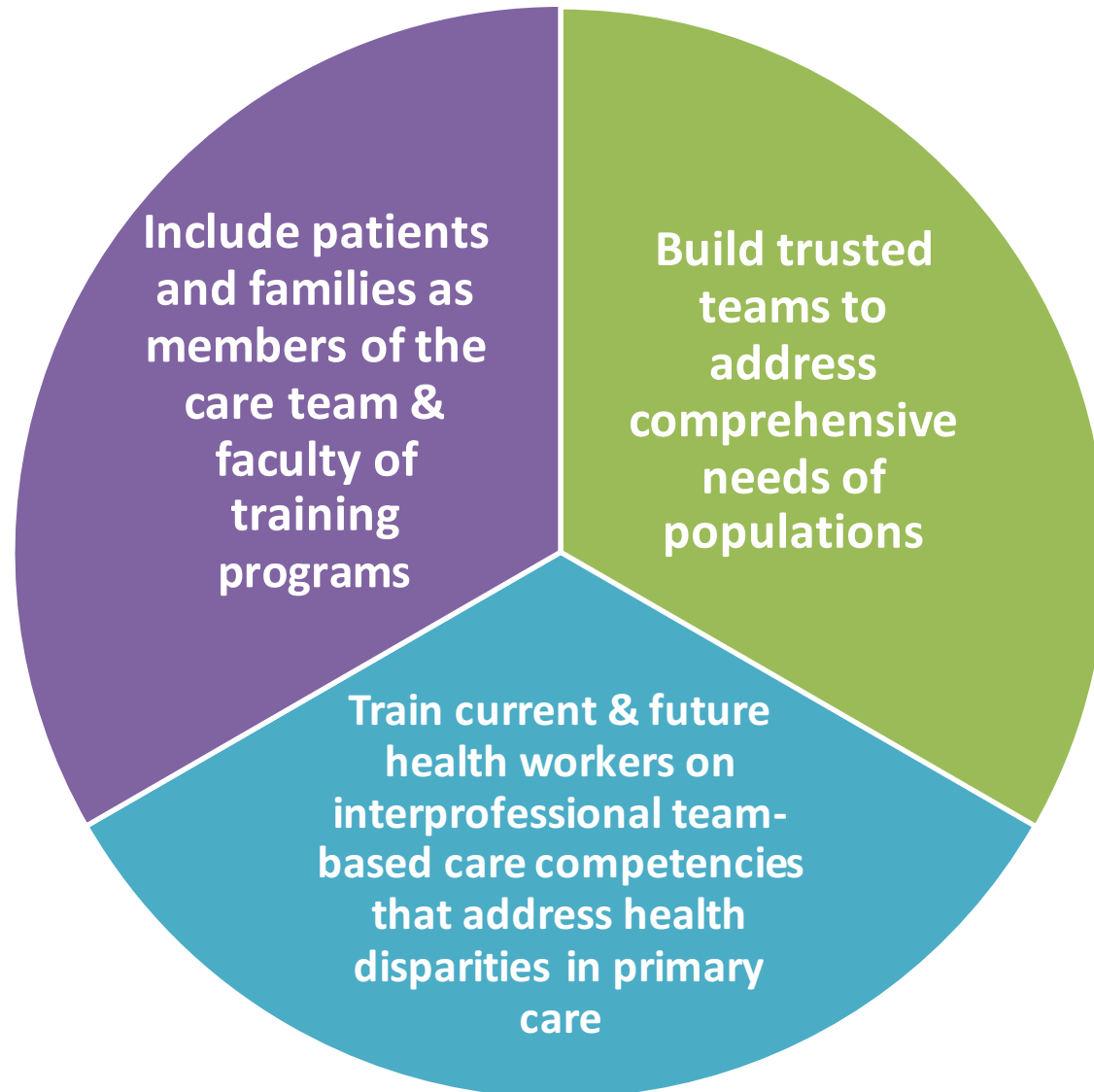


How do Families and Caregivers fit in?

Establish core components of recognized training to ensure the care team recognizes contributions of a **"family partner"**

- 1) Emotional support
- 2) Ability to discern where a patient or family member might be in the emotional process
- 3) Ability to walk with the patient/family through seasons of life or stages of the disease process
- 4) Community resource awareness
- 5) Family planning, goal setting
- 6) Healthy communication strategies that allow us to both hear and be heard
- 7) Support in other family relationships

Priority 4: Developing an Interprofessional Health Workforce to Support the PCMH



Preparing a Health Work Force for Team-Based Primary Care

- Define & promote effective team-based interprofessional care
- Develop a national strategy of IPE training – one that includes patients & families
- Integrate peer support into primary care and communities
- Allocate funding for primary care clinician training



Team-Based Primary Care Training Competencies

Developed in 2011 by PCPCC's Education & Training Task Force

Patient-Centered Care Competencies

- Advocacy for patient-centered integrated care
- Cultural sensitivity & competence in culturally appropriate practice
- Development of effective, caring relationships with patients
- Patient-centered care planning, including collaborative decision-making & patient self-management

Coordinated Care Competencies

- Care coordination for comprehensive care of patient & family in the community
- Health information technology, including e-communications with patients & other providers
- Interprofessionalism & interdisciplinary team collaboration
- Team leadership

Comprehensive Care Competencies

- Assessment of biopsychosocial needs across the lifespan
- Population-based approaches to health care delivery
- Risk identification

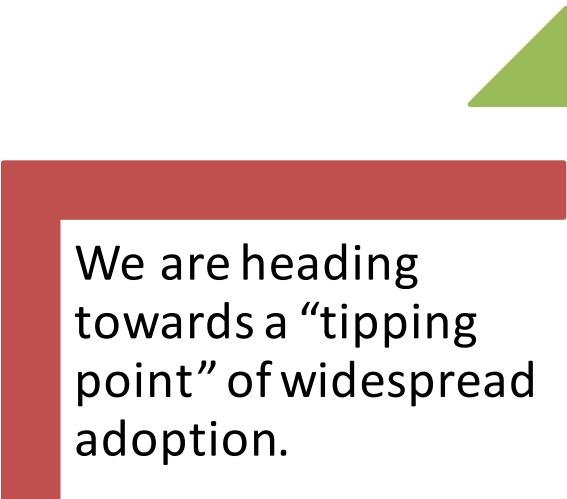
Accessible Care Competencies

- Promotion of appropriate access to care (e.g., group appointments, open scheduling)

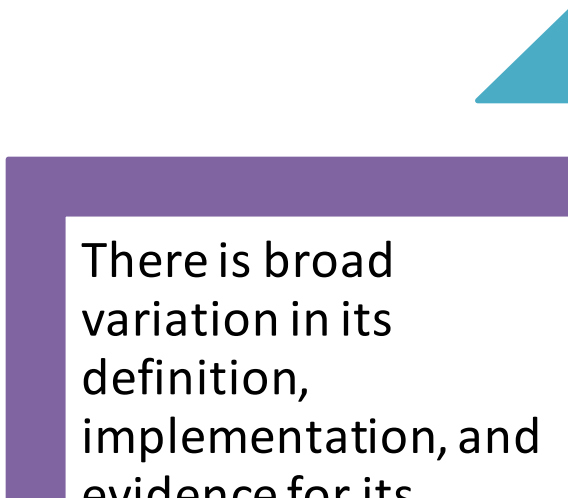
Care Quality & Safety Competencies

- Assessment of patient outcomes
- Business models for patient-centered integrated care
- Evidence-based practice
- Quality improvement methods, including assessment of patient-experience for use in practice-based improvement efforts

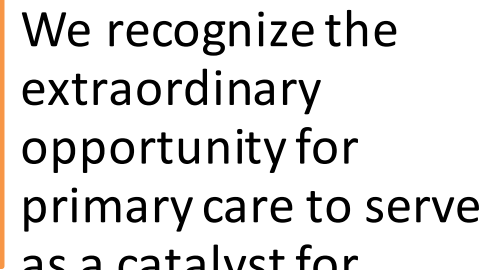
The Current Status of the PCMH



We are heading towards a “tipping point” of widespread adoption.



There is broad variation in its definition, implementation, and evidence for its success.



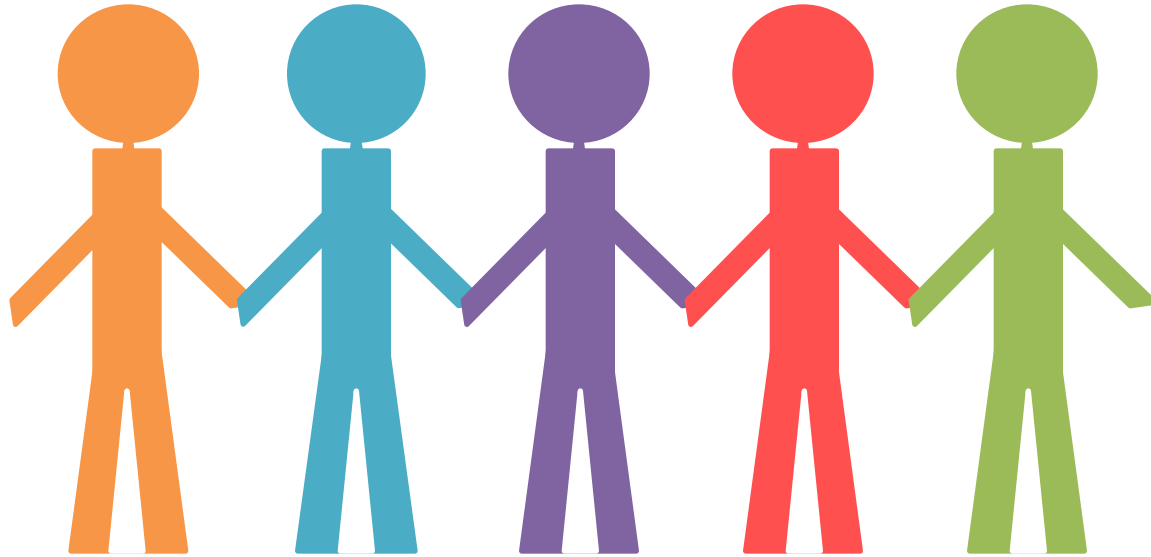
We recognize the extraordinary opportunity for primary care to serve as a catalyst for health system transformation.



How Can We Measure Our Collective Impact?

- Increased adoption of PCMH
- Increased investment in primary care
- Increased federal & state support for advanced primary care models
- Continuous quality improvement in primary care & “true” patient-centered practice transformation
- Aligning & engaging stakeholders to advocate for these strategic priorities

We stand ready to lead the charge!



The PCPCC stands ready to collaborate with partners, colleagues, and patients to make this health system transformation a reality as we implement these strategic priorities.

Join us on our journey

If your organization is dedicated to transforming health care to deliver more patient-centered, compassionate and accessible primary care...

**Become an Executive Member,
Attend our Annual Conference!**

Visit our website for more details:

www.pcpcc.org

Patient-Centered
Primary Care
COLLABORATIVE

Q&A

