



# 2010 Strategic Planning

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# 2010 Strategic Planning

## Introduction

A great deal has transpired since the Patient Centered Primary Care Collaborative (PCPCC) conducted its last strategic planning process a year ago, and the political landscape for healthcare reform has changed substantially in that interim. Irrespective of the ultimate outcome of healthcare reform, the need to transform primary care—both the delivery model and the reimbursement structure—has never been greater. At the same time, the final form of a healthcare reform bill is not yet clear at the time of this writing, suggesting that the PCPCC's plans for 2010 need to remain focused, yet flexible.

## Framework for the 2010 Plan

During last year's planning process, four main strategies were identified as appropriate focus areas for the PCPCC. These were:

1. Strengthen the health professions training pipeline to increase the production of highly trained primary care physicians needed for the nation's PCMHs;
2. Build the infrastructure for modernized, 21<sup>st</sup> Century PCMHs;
3. Reform payment policies in the private and public sector to support the PCMH;
4. Engage consumers as active partners in the PCMH.

During early conversations with Board and Executive Committee members, it was clear that people supported these focus areas but felt there had not been sufficient time to discuss them in detail at last year's planning retreat. A desire was expressed to delve further into each of these areas as part of this year's planning process. In addition, a number of people independently identified employer engagement as a fifth focus area they felt should be included. These five focus areas constituted the framework for the 2010 planning process just completed.

## The Planning Process

The planning process this year encompassed four major activities:

### I. Interviews

Twenty interviews were conducted with Board members, key staff and Center Co-Chairs. Key themes emerging from these interviews are summarized in a supplemental section at the end of this document. These themes served as the basis for the Executive Committee and Board Retreats.

### II. Executive Committee Retreat

A full-day retreat was conducted on September 1, 2009. All Executive Committee and Advisory Board members were invited, with approximately 45 in attendance. This group provided input and recommendations to the Board in each of the five focus areas. A summary of these inputs can also be found at the end of this document.

### III. Board Retreat

A retreat was conducted with the Board and key staff members on September 8, 2009, using inputs from the interview process and Executive Committee Retreat.

### IV. Strategic Goals

Additional meetings were held following the Board Retreat to achieve closure on strategic goals within each of the five focus areas, and align Center 2010 deliverables to these goals.

## Strategic Goals

During the Board retreat, individual Board members agreed to support the five strategic focus areas in a process of defining 2010 goals for those areas. Working groups were established with representatives from the relevant Centers. The final goals agreed to are presented on the following pages.

## Primary Care Workforce Pipeline Goals

1. Promote policies that provide for the Medical Home without limiting it to a subset of the population. Promote payment, coverage and other policies that include and improve the Patient-Centered Medical Home as a means to transform practices and delivery of care.
2. Promote multi-payer pilots of medical homes, including through federal programs such as Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), with broad patient participation and full transformation of practices.
3. In an effort to increase the primary care workforce, the PCPCC promotes:
  - a. Increased funding for National Health Service Corps Scholarship and Loan Repayment Programs.
  - b. Expanded primary care health professions programs in Sec. 747 of Title VII of the Public Health Service Act.
  - c. Providing additional pathways for scholarships and loan forgiveness programs to create incentives for new physicians to choose careers in primary care.
4. Increase Medicare, Medicaid, and private sector payments for primary care services.
5. Promote federal policy changes such that the Medicare Graduate Medical Education (GME) promotes an increase in primary care residency training programs.

## PCMH Implementation Infrastructure Goals

The PCPCC will advocate that the patient-centered medical home is implemented in a consistent manner by focusing on the following:

1. That all patient-centered medical home projects uses the National Committee for Quality Assurance (NCQA) Physicians Practice Connections (PPC) PCMH tool, or a similar, consensus-based recognition process that includes validation of PCMH practice attributes defined in the “Joint Principles.”
2. That the program evaluation models employ consistent, evidence-based guidelines, nationally-vetted consensus-based measures and an approach (e.g.,

randomized, case control, etc.) and measurement. promoting their adoption across various present and future PCMH pilot projects.

3. That the adoption of such standardized evaluation models demonstrates a core set of standard evaluation metrics that could be supplemented with other metrics to test.

The PCPCC will support the implementation of the patient-centered medical home by:

1. Actively working with other stakeholders to seek out and disseminate best practices for pilot evaluations and also seek out and disseminate best practices for PCMH project planning and implementation (at both the project management/convening level and the practice level) as well as for evaluations.
2. Serving as a dissemination center for medical home results, best practices and implementation infrastructure goals and data from already implemented programs.

## **Payment Reform Goals**

1. Develop a “state of the art” report on payment models being used in public payer and multi-payer PCMH demos.
2. Develop benchmarks for evaluating the impact of payment models being used in public payer and multi-payer PCMH demos on (a) sustaining the viability of the PCMH, (b) aligning incentives with the joint principles with a particular emphasis on “patient centeredness” and, (c) supporting primary care workforce goals.
3. Disseminate information on the most effective models based on such benchmarks.
4. Provide continued input on the payment models being implemented by CMS for Medicare, Medicaid, and all-payer demos, with the goals of supporting primary care workforce goals.
5. Provide continued input on the multi-payer payment models (Advanced Primary Care demo) being implemented by CMS with the goals of sustaining viability of the PCMH, aligning incentives with the joint principles, and supporting primary care workforce goals.
6. Develop a report on how payment incentives can be aligned with providing qualified PCMH practices with the financial support needed to incorporate health information systems to support patient-centered care within a PCMH and to align

such incentives with “meaningful use” to support the PCMH model as defined by HHS.

7. Develop recommendations on how employers can leverage their influence to encourage their employee benefit managers and health plans to implement changes in payment policies to support primary care workforce goals. Include recommendations on incorporating incentives for primary care in value-based benefit design.
8. Catalogue and disseminate successful efforts by employers to partner with health plans to implement changes in physician payment policies to support primary care workforce goals and the PCMH.

### **Consumer Engagement Goals**

1. Develop a PCPCC Consumer Center to enhance consumer leadership, broaden consumer involvement, spread the medical home concept and address the gaps and needs identified in the development of the patient centered partnerships necessary in medical homes.
2. Develop and/or establish consumer leadership, support, and engagement in all areas of the PCPCC: the Board, the Executive Committee/Advisory Board, and Centers, as well as the critically important federal and state political initiatives.
3. Identify the needs/gaps and potential strategies to overcome these gaps in consumer involvement, education and communication, and understanding at the federal, state and practice levels.
4. Based on the gaps identified, use--or develop-- family/patient-centered care information which facilitates the inclusion of consumers in practice-level medical home implementation and transformation.
5. Continue to work with NCQA/or other recognition programs to strengthen the inclusion of patient-centered and community-based measurements and interventions.

### **Employer Engagement Goals**

1. Recruit and engage more employers to participate in CBRI calls and the Patient-Centered Primary Care Collaborative.
2. Continue messages to employers of need to integrate and coordinate various benefit strategies that promote patient-centered medical homes and employee engagement.

3. Catalogue general employer behavior regarding the PCMH and share the results with other employer leaders to show traction.
4. Consider what business models actively encourage employer participation.
5. Consider methods through which to communicate with employers and improve consumerism.

## Center Deliverables

Please refer to Appendix A entitled “Business Implementation Plan” .

## Supplemental Information

### Strategic Planning Interview Summary

Twenty telephone interviews were conducted. These included the Board members, key staff, and 2-3 Co-Chairs from each of the four Centers.

### Key Interview Themes

The following themes emerging from the interviews provided the basis for our approach to strategic planning this year.

- The four strategic focus areas identified during the planning process last year were still felt to be critical. A new, fifth area was identified this year. These focus areas are:
  - Primary care workforce pipeline
  - PCMH implementation
  - Reimbursement reform
  - Consumer engagement
  - Employer engagement (added this year)
- There was general agreement that more substantive discussion was required in each of these areas.
- The Center Co-Chairs felt that they were driving short-term initiatives and deliverables without the benefit of a longer term strategic framework. In particular, they were interested in seeing the PCPCC’s longer term goals more clearly articulated in each of the five focus areas.

### Other Issues Identified During Interviews

Several other issues were identified as needing attention on a fairly urgent basis:

- The *limited availability of resources* presents a significant constraint for all of the Centers. Given the accelerated sense of urgency for primary care transformation under the new administration, there is a desire for the PCPCC to both do more and move faster. Accomplishing this will be challenging without additional staffing and financial resources.
- A closely related question is *sources of revenue*. Many interviewees felt that, while the EC membership model works well as a core revenue mechanism, especially when supplemented by occasional small grants for specific projects, the PCPCC should explore alternate sources of reliable funding on larger scale.
- Most interviewees identified the relationship between the Board and the Executive Committee as a *governance question* that needed to be addressed. Based on the interviews, as well as unsolicited input from a number of other Executive Committee members, the primary concerns of EC members appear to be as follows:
  - PCPCC is a multi-stakeholder collaborative, and there is a strong feeling that major constituent groups should be represented on the Board. A more diverse Board would also reinforce the integrity of the PCPCC as a broad coalition able to move beyond narrower agendas.
  - There is a concern that, at a time when PCPCC needs to become faster and more nimble in its ability to prosecute its mission, the apparent centralizing of decision making at the Board level is having the opposite effect. EC members fully support the Board's responsibility to review major policy questions and significant financial decisions, but question whether Board involvement in routine, tactical decisions represents a viable governance structure.
  - A formal governance role for the EC does not appear to be of particular concern if the above issues are addressed.

## Executive Committee Retreat Summary

Approximately 45 members of the Executive Committee and Advisory Board were in attendance. Another half dozen members participated by phone. The group was highly engaged, and there was time for substantive discussion around all of the focus areas.

### General Observations

Several general discussion topics are worth highlighting:

- The role of the PCPCC was broadly discussed and there was general agreement that this has included—and should continue to include—advocacy, convening, collaboration and best practice sharing.
- The question was raised as to whether the PCPCC should engage in content development. The consensus was that, while PCPCC is not primarily in the business of content development, there are frequently content gaps that need to be filled. It was felt that PCPCC should engage in content development, using member resources where needed, to close high priority gaps.
- The Centers are currently stretched for personnel given that most work is done on a volunteer basis. Increasing the level of effort will be extremely challenging without adding additional resources.

## **Recommendations**

Many specific recommendations were developed during the course of the meeting. These are organized below by major focus area. Although Reimbursement Reform and Employer Engagement are seen as distinct, many of the short-term recommendations are closely related, and thus are consolidated below.

### **PCMH Implementation**

- Develop clearly defined, broadly accepted criteria for evaluation design and compare it with existing national evaluation efforts.
- Identify critical elements for successful practice transformation.
  - Highest priority changes in terms of value for investment
  - Small enough number of things to be manageable for the practice
- Catalyze accelerated deployment of the medical home model on a broad basis; don't wait for current pilots to be complete. Make it scalable quickly.
  - Look to state-based rollouts as a potential model involving public and private payers, employers, and primary care association chapters (all provider groups)
  - Define what it's going to take to tool up: training, deployment model, resources
- Consolidate case studies and stories and broadcast successes with the right messaging and disseminate these stories to target consumers, employers, clinicians, payers and federal entities.

### **Reimbursement Reform/Employer Engagement**

- Form a short-term task force to take a close look at current legislative language. Is PCPCC position on payment reform principles clearly articulated?
- Educate and leverage employers more effectively:
  - Reinforce employer focus for CBRI (name change was also proposed)
  - Develop a clear business case for employers using existing data
  - Consolidate employer success stories
  - Develop an EBC strategy
  - Recruit more large employers to PCPCC
- Work for more standardization of the reimbursement model within individual markets. (Too difficult for practices when there are multiple models.)

### **Consumer Engagement**

- Convert the Consumer Task Force to a full-fledged Center
  - Involve key consumer organizations directly in the taskforce
  - Act as the voice of PCPCC to consumers and consumer groups
  - Message to consumers as a counter-balance to healthcare reform scare tactics
  - Coordinate consumer engagement activity within the PCPCC
- Develop employer approach to consumer engagement within CBRI

### **Primary Care Pipeline**

- Discuss the potential and worth of establishing a temporary taskforce to review this issue and develop specific recommendations - Areas of discussion to include:
  - PCPCC role as a convener and advocate in this arena
  - Improved curriculum in areas relevant to medical home and primary care transformation
  - Increased focus on team-based care
  - How training funds are spent
  - What other curriculum reforms efforts are underway

## **Progress On 2009 Plan**

Twelve potential issues were identified during last year's planning process. In some cases, specific recommendations were provided. Following is a brief overview of

progress on those recommendations during 2009.

### **Administrative Infrastructure**

High demands on a very small staff were identified last year as an area of opportunity. The group consensus was that the planning horizon for the organization should be at least five years, and that this justified the development of a permanent organizational infrastructure. During 2009, the PCPCC staff was enhanced by the addition of one full-time staff person and several additional consultants. Increasing permanent staff above current levels will likely require identification of additional sources of funding for the organization.

### **Governance**

The group consensus was that, given the large size of the Executive Committee, a smaller sub-group needed to be identified and charged with operational decision-making authority. During 2009, a Board of Directors was created to fill this role. The Executive Committee maintains an advisory capacity and provided significant input to the Board during this year's planning process.

### **Demonstrating Financial Value to Purchasers**

The recommendation here was that the PCPCC should include cost efficiency in the medical home, while taking care to avoid the promise of cost savings. In proving the value of the PCMH, assessment of costs should be built into evaluations of pilot demonstrations. Additionally, the PCPCC should address how these results are presented to purchasers and consumers. During 2009, the Center for Multi-stakeholder Demonstrations focused on pilot evaluation criteria that effectively demonstrate the value of the PCMH, while acting as a comment-seeking and dissemination body for the PCMH Demo Guidelines. The Center for Benefit Re-Design has had a significant focus on communicating the value of the PCMH to employers, and has been renamed the Center for Employer Engagement to clarify its focus on the purchaser perspective.

### **Realignment of Centers**

The question of new Centers was discussed last year, and an initial decision made not to add a Center for Consumer Engagement. Consumer engagement activity was subsequently delegated to an ad hoc task force and spread among the existing Centers during most of 2009. During the planning process this year, the issue was again raised, with a strong recommendation from some participants that PCPCC needed to elevate

Consumer Engagement to Center status to give it appropriate visibility.

### **Consumer Engagement**

The recommendation was made that PCPCC should engage in consumer awareness activities in several ways:

- Day-to-day operations, including a meeting focused specifically on consumer issues;
- PCMH messaging in partnership with consumer groups;
- Pilot evaluation of consumer satisfaction.

During 2009, an ad hoc task force was convened and an initial consumer meeting was held. Individual Centers also engaged in a variety of consumer-facing activities.

### **Medical Home Pilot Projects**

The group recommended that the Center for Multi-Stakeholder Demonstrations focus effort on seeking out and disseminating a standard evaluation framework and encouraged pilots to use this framework. The standard evaluation framework should assess changes in quality of care, patient satisfaction, and value to the payer. During 2009, the CMD focused significant effort in this area.

### **Physician Technical & Contracting Support**

A recommendation was made that the Center for Benefit Redesign and Implementation create a guide educating physicians on how best to contract their medical home services to purchasers. Given the many unknowns around pending healthcare reform legislation, this recommendation was not actively pursued during 2009. Once a healthcare reform bill is passed and the reimbursement rules are clear, the PCPCC may want to revisit the need for such a guide.

### **Promoting HIT Adoption**

No new recommendations were generated in this area during last year's planning process. CeHIA was encouraged to continue pursuing its targeted deliverables.

### **Primary Care Workforce**

It was suggested that this area might be better left to the primary care physician associations, although it was also suggested that the PCPCC Legislative Committee

consider any legislative policy statements on workforce issues. No specific recommendations were made during the planning process.

### **Lobbying and Government Relations**

The key goals and deliverables of the Center to Promote Public Payer Implementation were re-affirmed. No new recommendations were provided, other than the potential need to increase focus on payment reform.

### **Addressing the Role of Specialists, Nurse Practitioners, Physician Assistants and Pharmacists**

No specific recommendations were made in this area.

### **Dilution of Medical Home “Brand”**

The recommendations in this area were to leverage various partnerships to continue to reinforce a common definition of the PCMH via the Joint Principles, and to focus on establishing a consistent evaluation framework for pilots and finding efficient and effective ways of seeking out and disseminating best practices around the planning, implementation, and evaluation of PCMH projects.. Both of these received major attention in 2009.

**Appendix A – Business Implementation Plan**

**Center to Promote Public Payer Implementation**

**Fiscal Year 2009-2010 Deliverables**

Below is a list of desired deliverables by the CPPI leadership. Many of the CPPI deliverables are related to acting as a resource for those in or working with state and federal government programs.

<b>Deliverable</b>	<b>Estimated Resources Required</b>
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<b>Deliverable</b>	<b>Estimated Resources Required</b>
<p>Inform callers on “hot topics,” such as:</p> <ul style="list-style-type: none"> <li>– Return on investment projections</li> <li>– Health information technology infrastructure</li> <li>– Best practices for care coordination</li> <li>– Help navigating new federal legislation with regard to effect on Medicaid and SHIP programs</li> <li>– Identifying federal funding opportunities</li> </ul>	<p>CPPI leadership time; staff support; recruiting speakers for calls</p>
<p>More information on the publicly funded world</p> <ul style="list-style-type: none"> <li>- Private client/Investment Drives</li> <li>- How does Stimulus fund match state funding to clinics, how can this engage state and private insurance</li> <li>- How can we plan hospital investments on Meeting new patients needs in underserved areas (places of disparity)</li> <li>- Where are the medical homes from the legislature aspects? How is it going forward?</li> </ul>	<p>CPPI leadership time; staff support; recruiting speakers for calls</p>
<p>What is the Defense Military Perspective?</p> <ul style="list-style-type: none"> <li>- Some of these things are already paid for by the VA</li> <li>- Questions about how to see where there is overlap in the State Department</li> </ul>	<p>PCPCC staff time investigating speakers; CMD leadership time</p>

<b>Deliverable</b>	<b>Estimated Resources Required</b>
<p>Address the many permutations of payment reform seen in Medicare RUC recommendations, state Medicaid and SCHIP programs as well as other reimbursement methodologies related to supporting PCMH. This includes:</p> <ul style="list-style-type: none"> <li>- FFS Medicare, reimbursement that pays for quality of quantity</li> <li>- What are the pay-fors for demonstration projects?</li> <li>- Rural areas- how do you define meaningful care in these areas.</li> <li>- What are the resources necessary to become a medical home</li> </ul>	<p>CPPI leadership time; PCPCC research; recruiting speakers for calls; NASHP support</p>
<p>Advocating for PCMH model in Federal and State programs</p> <ul style="list-style-type: none"> <li>- Support states in developing legislation</li> <li>- Support PCMH Medicare demonstration pilot</li> <li>- Foster Medical Homes as a key element of Health Reform</li> </ul>	<p>Support from PCPCC in lobbying efforts at federal level; CPPI leadership time</p>
<p>Continue Medication Management Taskforce</p> <ul style="list-style-type: none"> <li>- Regular calls with all stakeholders</li> <li>- Develop Comprehensive Medication Management in the PCMH Guide as PCPCC Publication</li> </ul>	<p>CPPI leadership time, staff and resources for guideline development publication</p>
<p>Continue the CPPI bi-weekly calls*</p>	<p>CPPI leadership time; limited staff support</p>
<p>Develop and implement a process for seeking feedback on the CPPI calls so that they will continue to provide the participants with relevant and timely information*</p>	<p>CPPI leadership time; staff support</p>
<p>Continue contributions to the content of the PCPCC stakeholder meeting sessions, as well as to the PCPCC policy conference as needed</p>	<p>CPPI leadership time; limited staff support</p>

Deliverable	Estimated Resources Required
Update the CPPI portion of the PCPCC website to more accurately reflect the goals and expected deliverables of the CPPI, including the implementation of some interactive sections to better engage participants, if feasible	Staff support; limited CPPI leadership time

\* The CPPI leadership would like to second the CMD's leadership in recommending that the PCPCC consider developing a means of obtaining feedback on all Center and other PCPCC conference calls. This feedback could help determine if the current content and frequency of calls is appropriate. The CPPI leadership currently spends a significant amount of time planning for the bi-weekly calls, so if the calls were less frequent (perhaps once a month) then it is possible the leadership could devote more time to other goals and deliverables.

**Center for Multi-Stakeholder Demonstrations**

**Fiscal Year 2009-2010 Deliverables**

Below is a list of desired deliverables by the CMD leadership. It is recognized that not all of these deliverable could be reasonably produced in a 1-year timeframe; therefore, each one has a set of estimated general resource requirements listed in order to clarify for the Board what might be required for them to be produced.

Deliverable	Estimated Resources Required
Update the PCMH pilot compilation guide; convert it to an online resource – and develop an efficient, possibly interactive process for future updates	CMD leadership time; staff support; likely additional funding

<b>Deliverable</b>	<b>Estimated Resources Required</b>
Produce a guide to PCMH demonstration project evaluations (Underway)	External researcher; funding for survey and printing; limited CMD leadership time (note: all resources already acquired)
Continue the CMD bi-weekly calls*	CMD leadership time; limited staff support
Develop and implement a process for seeking feedback on the CMD calls so that they will continue to provide the participants with relevant and timely information*	CMD leadership time; staff support
Continue contributions to the content of the PCPCC stakeholder meeting sessions, as well as to the PCPCC policy conference as needed	CMD leadership time; limited staff support
Update the CMD portion of the PCPCC website to more accurately reflect the goals and expected deliverables of the CMD, including the implementation of some interactive sections to better engage participants, if feasible	Staff support; limited CMD leadership time
Continue active engagement in other PCPCC workgroups	CMD leadership time
Produce an antitrust “how to” guide for multi-payer PCMH demonstration projects	Possibly external assistance with writing; CMD leadership time; staff support; additional funding
Implement a learning collaborative (in-person and/or virtual) of PCMH demonstration project convening organizations to facilitate the exchange of best practices	External assistance with meeting planning; CMD leadership time; staff support; additional funding

Deliverable	Estimated Resources Required
Produce a series of white papers summarizing and providing guidance on key topic areas such as reimbursement, technical assistance, use of technology, patient attribution, antitrust, and convening entity issues—these papers could build on and/or complement some of the other deliverables listed above	Likely external assistance with writing; CMD leadership time; staff support; additional funding

- \* The CMD leadership would like to recommend that the PCPCC consider developing a means of obtaining feedback on all Center and other PCPCC conference calls. This feedback could help determine if the current content and frequency of calls is appropriate. The CMD leadership currently spends a significant amount of time planning for the bi-weekly calls, so if the calls were less frequent (perhaps once a month) then it is possible the leadership could devote more time to other goals and deliverables.

**Center for Employer Engagement**

**Fiscal Year 2009-2010 Deliverables**

Below is a list of desired deliverables by the CBRI leadership. It is recognized that not all of these deliverable could be reasonably produced in a 1-year timeframe; therefore, each one has a set of estimated general resource requirements listed in order to clarify for the Board what might be required for them to be produced.

<b>Deliverable</b>	<b>Estimated Resources Required</b>
<p>Prepare and release value based benefit design white paper that establishes the role benefit design has as the enabler for PCMH</p>	<p>Funding supplied by Pfizer. CBRI co-chairs are leading the project along with NBCH</p>
<p>Continue messages to employers of need to integrate and coordinate various benefit strategies that promote PCP care and employee engagement. Including but not limited to:</p> <ul style="list-style-type: none"> <li>• onsite primary care clinics and the PCMH universe</li> <li>• the new mental health parity legislation</li> <li>• HDHP coverage of preventive services</li> <li>• Possible need to incentivize employees to join patient-centered medical homes</li> <li>• Needed for employer-to- employee communication on PCMH</li> <li>• Role of data collectors - incidence of disease + adherence data</li> </ul>	<p>Bruce Sherman is working with OSCs organizations. Resources required TBD. Rob Dribbon is working on employer to employee communications task force.</p>
<p>Recruit and engage more employers to participate in CBRI calls and PCMH</p>	<p>CBRI leadership and PCPCC leadership to invite Boeing, Pitney-Bowes, Lowes, General Mills, Whirlpool to join calls</p>
<p>Continue the CBRI bi-weekly calls*</p>	<p>Planning of calls and hosting of calls is close to 6 hours not including work on white paper and task forces</p>

<b>Deliverable</b>	<b>Estimated Resources Required</b>
<p>Continue build PCMH Speakers Bureau with focus on employers messages and messengers. We have 30 potential speakers which does not include PCPCC board, executive council or center members.</p>	<p>Time from ED to build FAQ and slide deck</p>
<p>Develop a series of metrics for employers to track regarding the effectiveness of PCMH. The metrics set could also be used to help employers better understand why they need to consider PCMH, as well as their opportunity in terms of employee treatment compliance, preventive care compliance and healthcare cost reduction.</p> <p>For example, the list could include the number of individuals who have a PCP, total PCP costs in comparison to other healthcare costs, hospitalization rates, compliance with preventive care, etc.; all of which can be used to highlight the opportunity for improved quality care. This could actually evolve into a potential quality of care/cost-savings model for employers, depending on how involved this becomes.</p>	<p>Funding needed. Not sure how much but this proof of concept would help accelerate adoption of PCMH.</p>
<p>Continue to support work and showcase on CBRI calls the work of:</p> <ul style="list-style-type: none"> <li>• behavioral health task force</li> <li>• employer-to- employee communication task force</li> </ul>	<p>CBRI staff time</p>
<p>Develop and implement a process for seeking feedback on the CBRI calls so that they will continue to provide the participants with relevant and timely information*</p>	<p>CBRI leadership time; staff support</p>

<b>Deliverable</b>	<b>Estimated Resources Required</b>
Continue contributions to the content of the PCPCC stakeholder meeting sessions, as well as to the PCPCC policy conference as needed	CBRI leadership time; limited staff support
Update the CBRI portion of the PCPCC website to more accurately reflect the goals and expected deliverables of the CBRI, including the implementation of some interactive sections to better engage participants, if feasible	Staff support; limited CBRI leadership time
Continue active engagement in other PCPCC workgroups	CBRI leadership time

**Center for eHealth Information Adoption and Exchange**

**Fiscal Year 2009-2010 Deliverables**

Below is a list of desired deliverables by the CeHIA leadership. It is recognized that not all of these deliverable could be reasonably produced in a 1-year timeframe; therefore, each one has a set of estimated general resource requirements listed in order to clarify for the Board what might be required for them to be produced.

<b>Deliverable</b>	<b>Estimated Resources Required</b>
Continue work by four CeHIA task force groups; complete deliverables as identified; Meaningful Use (Janet Marchibroda), Decision Support (Jeff Hanson), Participatory Engagement (David Nace), IT Resource Center (Jim Crawford)	CeHIA leadership time; staff support; likely additional funding
Continue to provide leadership in exploring challenges and identifying best practices in operationalizing PCMH & HIT in physician practices	CeHIA leadership time; CeHIA member time; external resources as identified
Engage discussion and provide leadership in HIT on implementation of PCMH in health system environments	CeHIA leadership time; external resources
Engage discussion and provide leadership on the impact of PCMH-focused HIT on the cost and quality of care (i.e. ROI, care coordination, etc.)	CeHIA leadership time; external experts as identified; researchers; staff support
Move agenda forward in the area of HIT support for PCMH aligned Meaningful Use criteria that support measuring healthcare outcomes	CeHIA leadership time; staff support; external experts and researchers
Explore role of HIT-enabled data collection on patient experience of care, engagement and safety/quality	CeHIA leadership time; staff support; external researchers
Explore HIT challenges and vehicles for putting “primary” data back into the healthcare reform effort (i.e. biometrics, labs, imaging, pharma, acute care events, etc.) to assist with clinical decision support.	CeHIA leadership time; external experts and researchers
Continue to support PCPCC various resource center updates and enhancements	CeHIA leadership time; limited staff time
Continue to track and report to PCPCC and stakeholders on HIT policy and other government actions	CeHIA leadership time; external expert time as needed

<b>Deliverable</b>	<b>Estimated Resources Required</b>
Explore with PCPCC revenue-generating opportunities	CeHIA leadership time; perhaps staff support time

**Center for Consumer Engagement**

**Fiscal Year 2009-2010 Deliverables**

Below is a list of desired deliverables. It is recognized that not all of these deliverable could be reasonably produced in a 1-year timeframe; however, the estimated resources required is still to be determined.

<b>Deliverable</b>	<b>Estimated Resources Required</b>

<b>Deliverable</b>	<b>Estimated Resources Required</b>
Leverage new media mechanisms (21 <sup>st</sup> century vehicle)	TBD
Bring together consumer communities and peer supports	TBD
Look to successful models of consumer engagement including those outside of PCMH environment and consumer governance roles	TBD
Explore the establishment of focus groups	TBD
Provide more information from PCPCC and the four centers on how consumers can engage with PCPCC	TBD
Review and reorganize PCPCC resources based on consumer needs and perspectives	TBD
Create a page on PCPCC website for Frequently Asked Questions for consumers, regarding the Patient Centered Medical Home	TBD
Every practice partners with patients and families to redesign and improve care.	TBD
Develop education and engagement models for consumer organizations and their members	TBD
Test mechanisms for providing PCMH information to communities	TBD
Seek to establish infrastructure support for – clinical encounter triangle (MD, specialist, consumer)	TBD
Assist clinicians with improved understanding of patient peers/resources	TBD
Address the needs of large populations with both at-risk and diagnosed chronic illness	TBD
Address communication issues by comparing today's care to PCMH care: What we have now, what we would have in the future, what it means and what is your role	TBD