



Patient-Centered
Primary Care

COLLABORATIVE

www.pcpcc.net

PATIENT & QUALITY ORGANIZATIONS

- AARP • AFL-CIO • American Cancer Society
- American Geriatrics Society • American Heart Association • Arkansas Foundation for Medical Care • eHealth Initiative • Louisiana Health Care Quality Forum • National Committee for Quality Assurance • National Consumers League • National Partnership for Women & Families • New England Quality Care Alliance • New Hampshire Citizens Initiative • Practice Transformation Institute
- Robert Wood Johnson Medical School* • Service Employees International Union • The Center for the Advancement of Health • URAC

PROVIDERS

- Alere* • Amedisys, Inc. • American Academy of Family Physicians** • American Academy of Neurology • American Academy of Nurse Practitioners* • American Academy of Pediatrics**
- American Academy of Physician Assistants
- American Board of Internal Medicine • American College of Osteopathic Family Physicians • American Board of Medical Specialties • American College of Cardiology • American College of Nurse Practitioners* • American College of Osteopathic Internists • American College of Physicians**
- American Health Quality Association • American Medical Directors Association • American Medical Group Association • American Osteopathic Association** • American Psychiatric Association
- American Society of Addiction Medicine
- American Society of Consultant Pharmacists
- Association of Departments of Family Medicine
- Association of Maternal and Child Health
- Brigham and Women's Physicians Organization
- The Center for Excellence in Primary Care
- Cerner Corporation • The Collaborative Family Healthcare Association • College of American Pathologists • Colorado Center for Chronic Care Innovations • CVS Caremark* • EDS • Day Kimball Hospital • The Department for Family and Community Medicine, University of California, San Francisco • DMAA: The Care Continuum Alliance*
- EHE International* • Foundation for Informed Medical Decision Making • GlaxoSmithKline*
- Iowa Health Care Collaborative • Interim Healthcare* • Johns Hopkins Medicine Interactive
- Johnson & Johnson* • Healthways • LSU Health Sciences Center Shreveport Family Medicine
- Managed Transitions • Marathon Health
- Massachusetts Health Data Consortium
- Marillac Clinic, Inc. • MASSPRO • Mayo Clinic, Center for Innovation • Massachusetts Health Data Consortium • McKesson Corporation*
- MDdatacor • Medco* • Merck* • Michigan Primary Care Consortium • National Alliance on Mental Illness • National Association of Chain Drug Stores • National Association of Community Health Centers • National Association of Pediatric Nurse Practitioners* • National Organization of Nurse Practitioner Faculties • National Pharmaceutical Council • New England Quality Care Alliance
- New York City Department of Health and Mental Hygiene • Novartis* • Novo Nordisk*
- Nurse Practitioner Roundtable* • Ohio Department of Health • PhRMA* • Pfizer*

A More Cost Effective and Efficient Model of Health Care

Employers and public health care purchasers want to buy efficient, high quality health care, but the current transaction-based model doesn't recognize and pay for individualized, comprehensive, patient-focused care. The current reimbursement system is inadequate to account for care management. Information technology is insufficient and its adoption for both patient care and quality monitoring is not reimbursed. There is no financial incentive for a clinician to be accountable for whole patient care.

That's why the Patient-Centered Primary Care Collaborative was created—to change a system that doesn't work for patients, providers, or purchasers.

History of the Collaborative

In 2005 IBM began to question the very foundation of the health care it buys, and reached a significant conclusion: when compared to other industrialized countries, U.S. health care fails to deliver comprehensive primary care because of the way primary care is financed. Primary care is the only entity charged with the longitudinal care of the whole patient, and it is the primary care relationship that has the most profound effect on health care outcomes. The idea was shaped further when the term patient centered medical home was coined and took root with a number of large employers and primary care physician organizations.

PCPCC was created in late 2006, when the ERISA Industry Committee (ERIC) was approached by several large national employers with the objective of reaching out to the American College of Physicians, the Academy of Family Physicians, and other primary care groups in order to (1) facilitate improvements in patient-clinician relations, and (2) create a more effective and efficient model of health care delivery. To achieve these goals, the PCPCC has become one of the major developers and advocates of the patient centered medical home (PCMH) model in America.

The Collaborative's membership includes a number of large national employers, the major primary care physician associations, health benefits companies, trade associations, profession/affinity groups, academic centers, consumer groups, and health care quality improvement associations.

The PCPCC has created an open forum where health care stakeholders freely communicate and work together to improve the future of the American medical system. The Collaborative has developed language for inclusion in health reform proposals to support the patient centered medical home concept. It also acts as a key source for the continued education of congressional representatives, the federal and state governments, and individual practices on the patient centered medical home model as a superior form of health care delivery.

Patient centered care is defined as "care that is respectful of and responsive to individual patient preferences, needs, and values."

— Institute of Medicine





What Is “Patient Centered” Care?

Patient centeredness refers to health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care.

—Institute of Medicine,
Envisioning the National Healthcare Quality Report

Product

The result of this model will be:

- Healthier patients and savvy health care consumers;
- Reduced costs associated with coverage; and
- Empowered patients exercising a robust relationship with their primary care providers.

What is a medical home?

The patient centered medical home (PCMH) is an approach to providing comprehensive primary care to adults, youth and children. The PCMH will broaden access to primary care, while enhancing care coordination.

Clinicians practicing in the highest level medical home will:

- Take personal responsibility and accountability for the ongoing care of patients;
- Be accessible to their patients on short notice, for expanded hours, and open scheduling;
- Be able to conduct consultations through email and telephone;
- Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records;
- Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required;
- Advise patients on preventive care based on environmental and genetic risk factors they face;
- Help patients make healthy lifestyle decisions; and
- Coordinate care, when needed, making sure procedures are relevant, necessary, and performed efficiently.

How to get there

The key to this model is restructuring primary care reimbursement to incentivize the nature of the PCMH, including:

- Compensation for face-to-face consultations, as well as for those conducted over email and telephone;
- Monthly fees for services associated with coordination of care and monitoring of test results and procedures performed by other providers; and
- Implementation of a hybrid model of payment to include both **fee-for-service** based on hours of contact with patient; and **performance based incentives** and compensation for achieving measurable and continuous patient health improvements.



- Practice Transformation Institute • PRISM*
- The Roger C. Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health • sanofi-aventis* • Schering-Plough Corporation • Society of General Internal Medicine
- The Stoeckle Center at Massachusetts General Hospital† • Taconic IPA* • Thomas Group, Inc.*
- TransforMED* • University of Michigan Center for Value-Based Insurance Design • University of North Carolina Department of Family Medicine
- University of Pittsburgh Medical Center
- Walgreens Health Initiatives* • WellCentive, LLC†
- Wyeth • Wyoming Primary Care Association

PURCHASERS

- Boehringer Ingelheim Pharmaceuticals, Inc.*
- Bridges to Excellence • Caterpillar
- Commonwealth of Massachusetts • Country of Spain • Deloitte • Deloitte Consulting • Delphi Corporation • The Dow Chemical Company†
- Employer Health Care Alliance • Exelon Corp
- FedEx Corporation • Florida Health Care Coalition
- GE Energy • General Mills, Inc. • General Motors
- HR Policy Association • IBM*† • Maine Health Management Coalition • Medfusion* • Memphis Business Group on Health • Microsoft* • National Business Group on Health • National Business Coalition on Health† • National Coalition on Health Care • National Retail Federation • New York Business Group on Health • NextGen Healthcare Information Systems* • Oregon Coalition of Health Care Purchasers • The Pacific Business Group on Health • Philips Healthcare* • Phytel* • Puget Sound Health Alliance • The Proctor & Gamble Company • The Quantum Group* • Robert Bosch Healthcare* • Savannah Business Group • State of Massachusetts • State of Ohio • Thomson Reuters* • Towers Perrin • U.S. Chamber of Commerce
- United States Steel • Universal American Corporation* • Watson Wyatt • Wegmans Food Markets • Whirlpool Corporation • Xerox

PAYERS

- Aetna* • Anthem BCBS Ohio* • BlueCross BlueShield Association* • BlueCross BlueShield of Alabama* • BlueCross BlueShield of Arizona*
- BlueCross BlueShield of Massachusetts*
- BlueCross BlueShield of Michigan* • BlueCross BlueShield of Minnesota* • BlueCross BlueShield of North Carolina* • BlueCross BlueShield of Rhode Island* • BlueCross BlueShield of Tennessee*
- BlueCross BlueShield of Texas* • The Capital District Physicians’ Health Plan, Inc. • CIGNA*
- CVS Caremark* • Commonwealth of Massachusetts, Medicaid • Community Care Plan of Eastern Carolina • Geisinger Health Systems*
- Harvard Pilgrim Health Care • Health Care Service Corporation* • Henry Ford Health System
- Humana, Inc.* • Kaiser Permanente* • MVP Health Care* • MedAssurant* • Priority Health*
- SureScripts • UnitedHealthcare* • UPMC Health Plan* • WellPoint, Inc.*

* Designates member of PCPCC Executive Committee

† Designates PCPCC Board of Directors

Above is a partial list of PCPCC membership.

Center to Promote Public Payer Implementation

FUNCTION: Assist state Medicaid agencies and other public payers as they implement and refine programs to embed the patient centered medical home model by offering technical assistance, sharing best practices and giving guidance on the development of successful funding models.

Center for Multi-Stakeholder Demonstration

FUNCTION: Identify community-based sites to test and evaluate the concept; share information and best practices about pilots within a collaborative community; and serve as the connector to technical, quality improvement and education resources to facilitate ongoing demonstrations.

Center for Employer Engagement

FUNCTION: Create standards and buying criteria to serve as a guide and tool for large and small employers/purchasers in order to build the market demand for adoption of the medical home model.

Center for eHealth Information Adoption and Exchange

FUNCTION: Evaluate use and application of information technology to support and enable the development and broad adoption of information technology in private practice and among community practitioners.

Center for Consumer Engagement

FUNCTION: To engage the consumer in awareness activities in three ways: day-to-day operations, messaging and pilots. The CCE will focus on how the PCMH concept and its components are communicated to the public, partnering with large consumer groups.

Join the collaborative

Members of the Collaborative agree with the following tenets and become Signers to these basic principles:



The Patient-Centered Primary Care Collaborative is a coalition of major employers, consumer groups, organizations representing primary care physicians, and other stakeholders who have joined to advance the PCMH. The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the health care delivery system.

Employers, consumers, physicians and payers have agreed that the PCMH can be an important step toward creating payment systems for physicians that reward value. Compensation under the PCMH model would incorporate enhanced access and communication, improve coordination of care, rewards for higher value, expand administrative and quality innovations and promote active patient and family involvement.

The PCMH model will also engage patients and their families in positive ongoing relationships with their physicians. Further, the PCMH will improve the quality of care delivered and help control the unsustainable rising costs of health care for both individuals and plan sponsors.

To realize this vision, clinicians have additionally agreed to the following Joint Principles for patient centered primary care:

- The option to develop an ongoing relationship with a personal physician;
- Physician-directed medical practice;
- Whole person orientation;
- Coordinated care across the health system;
- Ongoing, voluntary pursuit of quality and safety;
- Enhanced access to care; and
- Payment recognizing the value added.

If you agree with our vision for a more efficient, cost-effective health care model, join the Collaborative by going to www.pcpcc.net, or call us at 202/724-3331.

Get Involved

You can help us achieve our shared goals by taking an active role in the Collaborative. Our members put our principles to work through the Center to Promote Public Payer Implementation, the Center for Multi-Stakeholder Demonstration, the Center for Employer Engagement, the Center for eHealth Information Adoption and Exchange and the Center for Consumer Engagement.



CONTACT: Edwina Rogers[†], Executive Director, Patient-Centered Primary Care Collaborative
The Homer Building ■ 601 Thirteenth Street, NW ■ Suite 400 North ■ Washington, DC 20005
202/724-3331 ■ Fax: 202/393-6148 ■ E-mail: erogers@pcpcc.net ■ www.pcpcc.net