Aligning and Engaging our Stakeholders to Drive Health System Transformation:
PCPCC’s Strategic Plan, 2015–2018

Our Mission

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is a 501(c)(3) membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCMH model embraces the relationship between primary care providers and their patients, families, and caregivers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation that improves outcomes and lowers costs. The PCPCC achieves its mission through the work of its five Stakeholder Centers, led by experts and thought leaders dedicated to transforming the U.S. health care system through delivery and payment reform, patient engagement, and benefit redesign.

Today, PCPCC’s membership includes more than 1,200 organizations throughout the United States that represent health providers across the care continuum, payers and purchasers, and patients and families that work collaboratively to:

- **Share results and outcomes** from advanced primary care and medical home initiatives and clearly communicate their impact on patient experience, quality of care, population health, and health care costs;
- **Educate public policymakers and the private sector** on the benefits of investing in team-based primary care and the PCMH; and
- **Convene a diverse group of thought leaders** including health care experts, patients, and families to promote awareness, innovation, and learning in patient-centered primary care.

The unique role that the PCPCC plays in the marketplace is based on the diversity and breadth of our membership and our mission to bring members together to collaborate across a broad set of interests. As such, this strategic framework builds explicitly on the PCPCC’s “unassailable niche” including its:

- Unmatched power to convene and engage a diverse constituency and membership.
- Reputation as the “go-to” group for taking the medical home to the most important audience - the public.
- Strong potential to obtain grants through strategic collaborations and program initiatives.
- History of effective member leadership, governance, and advocacy.
- Established medical home mindshare and market share.
- Effectiveness as an aggregator and disseminator of research, tools, model practices/initiatives, and other information related to the medical home.

Key Trends

The acknowledgement that primary care is central to a transformed U.S. health system has been critical in driving PCPCC’s mission and role, as well as articulating its value to our members and target audiences. The PCPCC’s strategic direction will continue to be driven by environmental trends in the marketplace and mission-based strategies, including the following:

**Testing and adoption of new payment models are expediting care delivery reform.** Driven by the need to reduce costs and improve efficiency, many emerging payment innovation models feature advanced primary care as a key solution to addressing these issues. U.S. Department of Health and Human Services (HHS) Secretary Sylvia Burwell jumpstarted the shift away from traditional fee-for-service payments with an announcement in early 2015 to move 50 percent of Medicare payments towards alternative payment models (e.g., ACOs, bundled payments, and PCMHs) by 2018. In addition, bipartisan legislation was passed in April 2015 to repeal and replace Medicare’s Sustainable Growth Rate (SGR)
PCPCC Strategic Plan (cont’d)

physician payment formula with a system that rewards value over volume. This new legislation, Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA), recognizes the PCMH as an approved care delivery and alternative payment model. Both of these initiatives dovetail with several new federal task forces and networks designed to support public and private partnerships of value-based payment reform (e.g., Health Care Payment Learning and Action Network; Health Care Transformation Task Force).

These payment reforms also emphasize key features of the medical home model, and are helping to reduce avoidable hospitalizations and the prevalence of preventable conditions. The PCPCC represents a ‘connector’ organization that can educate other stakeholders about the alignment of payment reform and care delivery innovations through its events, publications, resources, and other learning opportunities.

Transformation has spread as public and private industries invest more in primary care – and results have been impressive. Over the next four years, HHS plans to provide $840 million to support 150,000 clinicians in the Transforming Clinical Practice Initiative (TCPI), which is designed to help clinicians achieve large-scale transformation in the way they deliver health care services. Other large scale demonstrations released first year results in January 2015 including the Comprehensive Primary Care Initiative (CPC) – with over 2,000 providers and 2.5 million patients - and the Multi-Payer Advanced Primary Care Practice (MAPCP). Both of these initiatives showed early reductions in health care costs and unnecessary utilization - $4.2 million in savings for MAPCP and $14 PMPM (or 2 percent) for Medicare Part A and B expenditures for the CPC initiative. As described in PCPCC’s most recent annual evidence report (2015), primary care delivered in a PCMH is linked to reductions in health care costs and unnecessary utilization of services; improvements in population health and preventive services; increased access to primary care; and growing satisfaction among patients and clinicians.

Despite growing evidence about the medical home’s value and impact, some stakeholders remain uninformed or skeptical. The general public is largely unaware of the definition and value of the medical home. The term “patient-centered medical home” is not well understood by many, particularly consumers and others outside the core primary care space. In light of budget challenges and entitlement reform, there is even more pressure to move the emphasis beyond the medical home, to the larger health ‘ecosystem’ or medical neighborhood and the communities in which patients and families live. The PCPCC must advance the current dialogue beyond practice transformation, and position the PCMH as a critical element of health system transformation.

The PCPCC has emerged as a trusted and credible voice for articulating the medical home’s value and impact across industries and disciplines, and must continue to strengthen its voice on behalf of primary care and the PCMH. However, because the consumer has historically been insulated from their care decisions, they are generally under-informed or misinformed about the expectations and definitions of high-quality, patient-centered care. The PCPCC can be a unique resource that educates consumers about the benefits and features of high quality providers and practices, and can arm them with the knowledge and tools to make smarter choices and improve their health.

**Our Vision**

The PCPCC has played an instrumental role in placing the medical home at the center of health system transformation efforts and must continue to do so, especially as the private and public sector align their interests in favor of patient-centered primary care. However, while the PCMH model appears to be heading toward a ‘tipping point’ of widespread adoption, there is broad variation in its definition, implementation, and evidence of its success. To address this, the goals and objectives of this strategic plan will build on PCPCC’s unique leadership position, and will continue to strengthen its role as an educator, convener, advocate, and go-to resource across a wide range of stakeholders. The PCPCC recognizes that there is an extraordinary opportunity for the medical home to serve as a catalyst for health system transformation, and stands ready to collaborate with partners, colleagues, and patients to make this transformation a reality as it implements the strategic priorities outlined below.
### Strategic Priorities & Framework

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<th>1</th>
<th>Promote increased primary care investment</th>
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<td>The PCPCC supports moving towards risk-adjusted, comprehensive primary care payments from public and private payers as well as employers. This strategic priority will focus on controlling/reducing the total cost of health care by increasing the resources allocated to primary care and a commensurate shift from fee-for-service to value-based payments that support expanded teams and care delivery transformation to patient-centered medical homes. These payments will also incentivize practices to focus on improving patient experience of care and population health outcomes.</td>
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<th>Promote clinical transformation / integration with the neighborhood</th>
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<td>We will promote a shared definition of advanced primary care and the PCMH and define how to integrate its functions within the medical neighborhood, Accountable Care Organizations (ACOs), and communities. This includes integration both inside and outside of primary care practices. The PCPCC will develop new resources, tools, and supports to help clinicians and communities transform into high-performing, integrated systems of care.</td>
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<th>Promote patient, consumer, employee/employer engagement</th>
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<td>Engaging and educating consumers and employees in the communities they live, work and play is critical to advancing the primary care movement. Patients and families/caregivers should be working alongside clinicians and staff as partners on improving primary care practices. Employers and employees also need tools/resources to help them understand the value of advanced primary care models to ultimately drive access and utilization to these models. The PCPCC is committed to reaching these audiences and including them within the transformation process.</td>
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<th>4</th>
<th>Support an interprofessional team-based health workforce</th>
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<td>Few health professionals working in isolation can meet the comprehensive needs of a population without a trusted team that includes patients and their family/caregivers. As health care transitions into a more integrated, population, and value-based system, the PCPCC will help support the training of future and current health professionals in competencies related to working effectively in interprofessional team settings (e.g., forming teams, role development, promoting teamwork, etc.).</td>
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#### Strategies

- Push for payment reform that supports value over volume among public and private payers.
- Convene stakeholders to drive the development of a primary care investment measure/indicator.
- Measure and define primary care in terms of payment to providers.
- Connect with local and national patient/consumer groups to determine common outreach themes to engage the public in supporting investment in primary care. Integrate these identified themes into PCPCC educational tools.
- Promote primary care in value-based purchasing among employers/purchasers.

- Convene a work group on PCMH standards/accreditation that will develop and promote improved patient/consumer/employee perspectives into PCMH recognition models and promote administrative simplification for clinicians.
- Develop resources and case studies on the key features of high performing PCMHs and ACOs.
- Promote and publicize evidence-based integration of population health into primary care (e.g., behavioral health, oral health, medication management, etc.) using existing resources and tools from partner organizations.
- Help define and promote clinic- to community- linkages and address health disparities.

- Define and support patient-practice partnerships. Create forums to highlight how practices are partnering with patients/ families. Identify key patient-centered care attributes and develop advisor trainings.
- Develop principles and promote patient/family/caregiver experience metrics that support the goal of PCMH accreditation/recognition. Move metrics towards measuring practice transformation and meaningful engagement of patients/families in primary care.
- Partner on a public messaging campaign on the value of PCMH for employees/employers. Test messages with focus groups and develop consumer-facing educational tools.

- Help define and promote effective team-based care for interprofessional primary care settings. Include patients and families as members of the team.
- Partner with interprofessional organizations to develop a national strategy of interprofessional practice and education training that includes patients/families as faculty.
- Promote the integration of peer support into primary care and communities (e.g., community health workers) to address health disparities in collaboration with national and state leaders.
- Support federal and state funding for primary care clinician training to accommodate the primary care workforce needs of the future.