Opening General Session

Sunday, October 12
8:00 a.m.–noon
Convention Center:
Grand Ballroom D

Moderator: Gary C. Yee, Pharm.D., FCCP, BCOP
Professor and Associate Dean, University of Nebraska Medical Center, College of Pharmacy,
Omaha, Nebraska

Agenda

8:00 a.m. Keynote Address—Patient-Centered Care and the PCMH—Where Are We, REALLY, and Where Do We Need to Go?
Activity No. 0217-0000-14-098-L04-P; 1.0 contact hour; Knowledge-based activity.

Marci Nielsen, Ph.D., MPH
Chief Executive Officer, Patient-Centered Primary Care Collaborative, Washington, D.C.
9:00 a.m. Presentation of ACCP Awards

ACCP Education Award
Joseph J. Saseen, Pharm.D., FCCP, FASHP, BCPS, BCACP
Professor and Vice Chair, Clinical Pharmacy, Professor, Family Medicine, University of Colorado Anschutz Medical Campus, Skaggs School of Pharmacy & Pharmaceutical Sciences, Aurora, Colorado

ACCP Clinical Practice Award
Michael E. Klepser, Pharm.D., FCCP
Professor of Pharmacy, Ferris State University, Kalamazoo, Michigan

Russell R. Miller Award
Rita R. Alloway, Pharm.D., FCCP, BCPS
Research Professor, Director, Transplant Clinical Research, University of Cincinnati, Cincinnati, Ohio

Paul F. Parker Medal for Distinguished Service to the Profession of Pharmacy
Joseph T. DiPiro, Pharm.D., FCCP
Dean, School of Pharmacy, Virginia Commonwealth University, Richmond, Virginia
9:45 a.m. Outgoing President’s Address
Gary C. Yee, Pharm.D., FCCP, BCOP

10:00 a.m. Incoming President’s Address
Judith Jacobi, Pharm.D., FCCP, BCPS
Critical Care Specialist, Indiana University Health Methodist Hospital, Indianapolis, Indiana

10:20 a.m. Break

10:30 a.m. Therapeutic Frontiers Award Lecture—Barry Massie, M.D.: A Career at the Frontier of Heart Failure Research
Activity No. 0217-0000-14-099-L04-P; .75 contact hours; Knowledge-based activity.

Speaker: Barry Greenberg, M.D.
Professor of Medicine, Director, Advanced Heart Failure Treatment Program, University of California San Diego, La Jolla, California

Award Winner: Barry M. Massie, M.D.
Former Chief, Cardiology Division, San Francisco VAMC, San Francisco, California
11:15 a.m.  Research Institute Presentation  
Larisa H. Cavallari, Pharm.D., FCCP, BCPS  
Chair, Board of Trustee’s Research Institute, American College of Clinical Pharmacy; Associate Professor, Director Center for Pharmacogenomics, College of Pharmacy, University of Florida, Gainesville, Florida

11:30 a.m.  Recognition of New Fellows of the American College of Clinical Pharmacy

Conflict of Interest Disclosures

Barry Greenberg: no conflicts to disclose.  
Marci Nielsen: no conflicts to disclose.

Learning Objectives

Keynote Address—Patient-Centered Care and the PCMH—Where Are We, REALLY, and Where Do We Need to Go?

1. Discuss the current evidence supporting the transformation of the U.S. primary care delivery system to the Patient-Centered Medical Home (PCMH) framework.
2. Identify the current gaps and challenges in that transformation process related to policy, delivery system, and payment reform areas.
3. Identify the contribution of the team-based approach to comprehensive medication management to achievement of the overall goals of a highly functional PCMH.
4. Describe the importance of actual team member performance in achieving PCMH goals – getting things done as a “working” clinician.
5. Explain opportunities in both practice and research from full participation in primary care’s transformation.

Therapeutic Frontiers Award Lecture—Barry Massie, M.D.: A Career at the Frontier of Heart Failure Research

1. Describe how vasodilator drugs improve cardiac performance in patients with heart failure and/or valvular regurgitation.
2. Define the role of neurohormonal blocking agents in treating patients with heart failure.
3. Describe the effects of angiotensin receptor antagonists on the clinical course of patients with heart failure and preserved ejection fraction.

**Self-Assessment Questions**

Self-assessment questions are available online at www.accp.com/am

**Handouts will be available after the ACCP Annual Meeting**
Objectives

• DEFINITION & EVIDENCE.
  - Discuss the current evidence supporting the transformation of the U.S.
    primary care delivery system to the Patient-Centered Medical Home (PCMH) framework.

• GAPS & CHALLENGES.
  - Identify the current gaps and challenges in that transformation process related to policy, delivery system, and payment reform areas.

• COMPREHENSIVE MEDICATION MANAGEMENT.
  - Identify the contribution of the team-based approach to comprehensive medication management to achievement of the overall goals of a highly functional PCMH.

• TEAM-BASED CARE.
  - Describe the importance of actual team member performance in achieving PCMH goals – getting things done as a “working” clinician.

• PRACTICE & RESEARCH
  - Explain opportunities in both practice and research from full participation in primary care’s transformation.

Patient-Centered Care and the PCMH – where are we, REALLY, and where do we need to go?

Marci Nielsen, PhD, CEO
ACCP Conference, October 12th, 2014

Transformation requires...

Delivery reform: Growing evidence to support that it works

Payment Reforms: Necessary to sustain the model (and the progress made)

Benefit Redesign: Need employer and health plan engagement
**Public Engagement:**
Patients, Families & Caregivers, and Consumers must drive demand for the model

**DEFINITIONS & EVIDENCE**

**National Imperative: “Triple Aim”**

Better Patient Experience

"Triple Aim"

Lower Per Capita Health Care Costs

Improved Quality (better outcomes)

**Defining the medical home**

The medical home is an approach to primary care that is:

- Patient-Centered
  - Supports patients in managing decisions and care plans

- Comprehensive
  - Whole-person care provided by a team

- Coordinated
  - Care is organized across the ‘medical neighborhood’

- Accessible
  - Care is delivered with short waiting times, 24/7 access and extended in-person hours.

**Improving individual health to improve population health**

- Acknowledging drivers of health behavior and health status
  - Moving away from “patient education” toward “patient self-engagement”
  - Working at institutional and policy levels to focus on patient

McGinnis et al., Health Affairs 21(2):78-93 (2002)
Solutions = Strengthened primary care

Significant problems
- Rising healthcare costs $2.4 trillion (17% of GDP)
- Gaps/variation in quality and safety
- Poor access to PCPs
- Below-average population health
- Aging population

“Experiments” underway
- PCMHs
- ACOs
- EMR/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

The reports of our death are greatly exaggerated.

Methods

Reported outcomes are divided into 6 categories:

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

Primary Care Innovations and PCMH Map

What is a Medical Home?

Filter Results by Outcome

Go to the “Outcomes View” for PCPCC’s Primary Care Innovations and PCMH Map http://www.pcpcc.org/initiatives/evidence
## Reported Outcomes: Cost Savings

<table>
<thead>
<tr>
<th>Program</th>
<th>Outcomes</th>
<th>Date Published</th>
<th>Report Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem BC ACO</td>
<td>$8.7 Million (6 months)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Oregon Coordinated Care Organizations (Medicaid)</td>
<td>18-20% reduction on ED visit spending</td>
<td>Nov 2013, June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Vermont Blueprint for Health (Multi-Payer)</td>
<td>Reduced expenditures in 2012 by: • $56.7MM (inpatient) • $55.8MM (ER visits) • $30.3MM (Medicaid) • $44.7MM (Medicaid)</td>
<td>Jan 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>CareFirst BCBS PCMH Program (DC, MD, VA)</td>
<td>$24.7 million avoided costs (2012-2013)</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Monarch Healthcare CMS Pioneer ACO (CA)</td>
<td>5.4% reduction in medical costs in 2012 (Medicare)</td>
<td>Jan 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Horizon BCBS of New Jersey PCMH Program</td>
<td>$4.5 million savings (ER visits and hospitalizations) 4% lower total cost of care (all pts) 4% lower cost of care (diabetes pts)</td>
<td>July 2014</td>
<td>Industry Report</td>
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## Reported Outcomes: Improved Access

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<tr>
<th>Program</th>
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</thead>
<tbody>
<tr>
<td>BCBS Michigan PCMH Program</td>
<td>21.3% lower ER visits (pediatric) due to appropriate timely PC</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Maryland Multi-Payer PCMH Program</td>
<td>Statistically significant improvement in patient access to care (based on survey data)</td>
<td>Feb 2014</td>
<td>Peer-Reviewed</td>
</tr>
<tr>
<td>New York Health Homes (Medicaid)</td>
<td>14% increase in primary care visits</td>
<td>March 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Oregon Coordinated Care Organizations</td>
<td>18% increase in outpatient PC visits 30% increase in PCMH enrollment</td>
<td>Nov 2013</td>
<td>Industry Report</td>
</tr>
<tr>
<td>VA Patient-Aligned Care Team (National)</td>
<td>• Increased phone encounters (from 2.7 to 28.8% of patients/quarter) • Increased use of personal health records (6% to 11% enrolled pts) • Increased electronic messaging to providers (5% to 3.5% pts/pt) • Increased same day appr (pt/2) • Increased in patients seen within 7- days of desired appointment date (85% to 90%, pt/2)</td>
<td>July 2013</td>
<td>Peer-Reviewed</td>
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## Reported Outcomes: Improved Patient/ Clinician Satisfaction

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<thead>
<tr>
<th>Program</th>
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<th>Report Type</th>
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</thead>
<tbody>
<tr>
<td>BCBS Michigan PCMH Program</td>
<td>3.5% - 5.2% higher adult quality composite score (2009-2010)</td>
<td>July 2013</td>
<td>Peer-Reviewed</td>
</tr>
<tr>
<td>Fresno PCMH Initiative (CA-AFP)</td>
<td>Overall improvement in patient satisfaction</td>
<td>Feb 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>RHODE ISLAND CHRONIC CARE SUSTAINABILITY INITIATIVE (MULTI-PAYER)</td>
<td>Practices increased their positive patient experience ratings for access to care • Communication with care team • office staff responsiveness • shared decision-making • self-management support</td>
<td>May 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>VA Patient Aligned Care Team (National)</td>
<td>Lower staff burnout in PCMH practices (D2: 2.9 to 2.6, pt/2)</td>
<td>June 2014</td>
<td>Peer-Reviewed</td>
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## Reported Outcomes: Fewer ED/Hospital Visits

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<th>Report Type</th>
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<tbody>
<tr>
<td>Anthem BC ACO - New York</td>
<td>10% fewer hospital admissions (BESTMED Medical Group, year 2)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>CareFirst BCBS PCMH Program (DC, MD, VA)</td>
<td>6.4% fewer hospital admissions</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>BCBS Michigan PCMH Program</td>
<td>11.1% fewer hospital days</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Missouri Health Homes (Medicaid)</td>
<td>6.8% decrease in ED use 10.1% decrease in hospitalizations</td>
<td>March 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>New York Health Homes (Medicaid)</td>
<td>10% decrease in hospital admissions and ED visits</td>
<td>March 2014</td>
<td>Industry Report</td>
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## Reported Outcomes: Improved Health

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<tbody>
<tr>
<td>Anthem BC ACO (CA)</td>
<td>Increase in meeting quality measures: • 7.5% LDL (diabetes) • 3.8% in cholesterol management for heart disease patients</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>CareFirst PCMH Program (DC, MD, VA)</td>
<td>• 3.7% higher quality scores for panels receiving incentives • 9.3% higher quality scores for PCMH panels (2011-2012)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Horizon BCBS NJ PCMH Program</td>
<td>• 14% higher rate in improved diabetes control • 12% higher in cholesterol management</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>South Central Pennsylvania Alliance</td>
<td>Improved blood pressure control from 67% in 2012 to 79% in 2013 (East Berlin Family Medicine practice)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Fresno PCMH Initiative (CA-AFP)</td>
<td>50% increase in diabetes patients with controlled blood sugar after 1 year</td>
<td>Feb 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Primary Care Information Project (NY Medicaid)</td>
<td>Outperformed non-PCMH practices on ER control in hypertension/diabetes patients, and smoking cessation intervention measures</td>
<td>June 2014</td>
<td>Peer-Reviewed</td>
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## Reported Outcomes: Increased Preventive Services

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<tbody>
<tr>
<td>Horizon BCBS NJ PCMH Program</td>
<td>8% higher rate in breast cancer screenings 6% higher rate in colorectal screenings</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Hudson Health PCMH (CT-Medicaid)</td>
<td>CHILDREN seen in PCMH 92% more likely to receive recommended EPIDET screenings</td>
<td>July 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>MGH-PCMH Initiative (CT-Medicaid)</td>
<td>85% participation in annual physical led to increase in preventive screening rates and diabetes guidelines (2012)</td>
<td>Jan 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Oregon Coordinated Care Organizations (Medicaid)</td>
<td>58% increase in children seen for risk of developmental, behavioral, and social delays (2011)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>South Central Pennsylvania Alliance</td>
<td>Tobacco cessation counseling improved from 36% in 2010 to 86% in 2013 (East Berlin Family Medicine practice)</td>
<td>June 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Vermont Blueprint for Health (Multi-Paper)</td>
<td>• Increased screenings for breast and cervical cancer (adult commercial &amp; Medicaid) • Increased adherence and care visits</td>
<td>Jan 2014</td>
<td>Industry Report</td>
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Opening General Session

Reported Outcomes: Behavioral Health

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<th>Program</th>
<th>Outcomes</th>
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<th>Report Type</th>
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<tbody>
<tr>
<td>Georgia PCMH University</td>
<td>Depression screening rate in elderly increased from 11% to 55% (vs. PCMH-2) 2 every visit</td>
<td>2013</td>
<td>Industry Report</td>
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<tr>
<td></td>
<td>6% improvement in rate of tobacco cessation counseling</td>
<td></td>
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<tr>
<td>VHA Patient-Aligned Care Teams (integrated bi, full-time BH coordinator at each facility)</td>
<td>Lower ED use</td>
<td>June 2014</td>
<td>Peer-Reviewed</td>
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<td></td>
<td>Lower hospitalization rates</td>
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<td></td>
<td>Lower staff burnout</td>
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<td></td>
<td>Higher scores of patient satisfaction</td>
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<tr>
<td>Missouri Medicaid Health Home</td>
<td>8.5% decrease in ED use</td>
<td>March 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td></td>
<td>10.13% decrease in hospital admissions</td>
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<td></td>
<td>Cost savings of $132 PMPM</td>
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<tr>
<td>New York Medicaid Health Home</td>
<td>23% decrease in hospital admissions and ED visits</td>
<td>March 2014</td>
<td>Industry Report</td>
</tr>
<tr>
<td></td>
<td>14% increase in primary care visits</td>
<td></td>
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<tr>
<td>Rhode Island Chronic Care Sustainability Initiative (Multi-Payer)</td>
<td>Practices met every targeted patient health outcome and show improvement over time (e.g., weight management, diabetes, high blood pressure, tobacco cessation)</td>
<td>May 2014</td>
<td>Industry Report</td>
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Reported Outcomes: Oral Health

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</thead>
<tbody>
<tr>
<td>North Carolina Pediatric and General Dentist (population survey)</td>
<td>Awareness of AAPD referral guidelines found to significantly lower relative risk of recommending that physicians wait to refer children without teeth</td>
<td>2014</td>
<td>Peer-Reviewed</td>
</tr>
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<td></td>
<td>Enrollees receive cost-sharing reductions if commitment to two free dental cleanings per year (among others). Program results:</td>
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<td></td>
<td>22.9% fewer monthly ED visits</td>
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<td></td>
<td>75% increase in PC visits</td>
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<tr>
<td>Connecticut Health Enhancement Program (State Employees)</td>
<td>75% reduction in medical trend growth rate (diabetes)</td>
<td>Jan 2013</td>
<td>Industry Report</td>
</tr>
<tr>
<td>Institute for Family Health PCMH Program (Manhattan &amp; Hudson Valley – NY Medicaid)</td>
<td>8 of those programs also offer dental services. Program results:</td>
<td>May 2013</td>
<td>Peer-Reviewed</td>
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<td></td>
<td>Reduced mean annual A1c levels from 10.7% to 8.3%</td>
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<td></td>
<td>Increased access to psychosocial, diabetes education, and primary care services (diabetes patients)</td>
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<td></td>
<td>Increased patient outreach services, diabetes education support, and HBA1c monitoring &amp; testing.</td>
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Health care expenditures per person

Requires industry & government solutions

Trends in National Health Spending: Public versus private

Health care “waste” = Overuse, Underuse, Misuse

Footnotes:

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Top 5 conditions in the workplace = Tied to behavioral/mental health

Suicide rate rises as other chronic illnesses begin to decline

Primary Care Remains Undervalued

Emerging Payment Reform Trends
**Authentic Patient Engagement and Activation**

SOM (2002); modified from Dahlgren and Whitehead (1991)

**Patient activation is developmental & predicts health behaviors**

Research consistently finds that those who are more activated are:
- Engaged in more preventive behaviors
- Engaged in more healthy behaviors
- Engaged in more disease specific self-management behaviors
- Engaged in more health information seeking behaviors

Source: Hibbard, University of Oregon

**Terminology preferred by patients and consumers**


**A Multidimensional Framework For Patient And Family Engagement**


©2013 by Project HOPE
Trends In Monthly Medicare Parts A And B Spending For Part D Enrollees With Diabetes, By Drug Adherence Status With ACE Inhibitors Or ARBs, 2006-08.

Why the Medical Home Works: A Framework

Potential Impacts

Potential Impacts

Lower Per Capita Costs? Manage high-risk, high need populations

Working with patients based on their needs
Better Patient Experience of Care?  
*Improved Access to Care & Compassionate Care*

- 24/7 access to care team (phone or e-consults with nurses, etc.)
- Open scheduling & alternatives to traditional face-to-face visits, including telemedicine, group visits, e-consults
- Culture of compassion and personal relationship with patient
- Communication, communication, communication!

Improved Population Health Outcomes?  
*Care is coordinated and data shared electronically*

- Data shared across providers and institutions available at point of care and referrals are tracked
- Patients engaged through electronic records, portals, mobile apps, email
- Focus on whole person and recognition of behavioral health needs
Trajectory to Value-Based Purchasing

It is a journey, not a fixed model of care

Value-Based Purchasing: Reimbursement Tied to Performance on Value

Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination$ Value/Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures

Supportive Base for ACOs, PCMH Networks, Bundled Payments, Global Capitation

Primary Care Capacity Patient Centered Medical Home

HIT Infrastructure: EHRs and Connectivity

Source: THINC - Taconic Health Information Network and Community

ACO Growth Since 2011

Value-Based Purchasing - It is a journey, not a fixed model of care

Source: THINC - Taconic Health Information Network and Community

How ACOs today differ from 1990’s “Managed Care/Cost Organizations”

Accountable Care
- First and foremost, providers
- “Gateway” to system through primary care
- Mix of Fee-For-Service (FFS) with shared savings and shared risk; or partial capitation
- Payment also linked to quality targets

Capitated Managed Care
- First and foremost, insurers
- “Gatekeeping” that limited provider choice
- Full capitation where providers carried vast majority of risk
- Rarely included payment linked to quality

Frakt, AB and Mayes, R (2012) Health Affairs
Opening General Session

Value-Based Insurance Design

• **Decreasing** consumer cost-sharing for interventions that are known to be effective
• **Increasing** consumer cost-sharing for those that are not known to be effective
• Providing **financial incentives** to providers to be medical homes
  – Increase Case Rates/PBPM
  – Increase Bonus/Shared Savings
• Providing **education to employees** to use high-value, and avoid low-value, interventions

Health Plan Tools & Transparency for Consumers

• **98%** of plans offer/support a cost calculator
• **77%** of hospital choice tools have integrated cost calculators
• **77%** of physician choice tools have integrated cost calculators
• **86%** of plans report benefit design details (copays, cost sharing, and coverage exceptions)
• **Only 2%** of total enrollment use these tools

Transformation Lessons Learned

• **A strong foundation is needed for successful redesign.**
  – Broad organizational support, previous experience with teams, financial stability, focus & commitment with few distractions
• **The process of transformation can be a long and difficult journey.**
  – Ambitious & challenging and requires time, dynamic & time intensive with ebbs and flows, requires deep changes in structures and systems, tensions & trade-offs should be expected
• **The approaches to transformation vary.**
  – Increased use of team-based care, expanded patient access & improved coordination, data-driven measurement & feedback, formal or informal learning collaboratives


Source: National Scorecard on Payment Reform, 2013

VISIT THE PCMH MAP AT WWW.PCPCC.ORG/INITIATIVES

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About PCPCC – or “the Collaborative”

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.

Activities
- Strengthening public policy that advances and builds support for primary care and the medical home
- Disseminate results and outcomes from medical home initiatives and their impact on outcomes, quality and costs
- Convene health care experts and patients to promote learning, awareness, and innovation of primary care and the medical home

History of PCPCC

National not-for-profit coalition founded in 2006 to:
- Facilitate achievements toward the Triple Aim: better health, better care experience, and health care cost control
- Create a more effective and efficient model of healthcare delivery, grounded in primary care
- Acts as conveners to bring together thought leaders and stakeholders to address challenges, opportunities, and barriers to health system transformation
- Contributed to developing PCMH language for health reform proposals
- Published dozens of reports

Membership

Since 2006, PCPCC membership has grown to represent more than 1,000 organizations providing care to 50 million Americans, including:
- Provider associations
- Large employers
- Health plans
- Providers & health systems
- Pharmaceutical firms
- Policymakers
- Patient advocacy groups

Role of the Collaborative

- Challenge the status quo and drive the marketplace
- Disseminate timely information and evidence
- Provide networking & educational opportunities

Everyone doing their part…
Everything is Awesome!

Contact:
Marci@pcpcc.org
www.pcpcc.org