Patient-Centered Primary Care Collaborative, Commonwealth Fund, Dartmouth Institute release landmark consensus document on ACOs, medical homes

Better to Best represents unprecedented accord among stakeholders

Washington, D.C. March 30, 2011-- New models of care, such as patient centered medical homes and accountable care organizations, must emphasize value-driving elements of advanced primary care--enhanced access, better care coordination, use of health information technology to support care transformation, and payment models that reward coordinated care. For the first time, stakeholders across a range of sectors have reached a consensus on how to make this happen.

The Patient-Centered Primary Care Collaborative, in partnership with The Commonwealth Fund and the Dartmouth Institute for Health Policy and Clinical Practice,has released Better to Best: *Value-Driving Elements of the PCMH and ACO*. The report was funded by the Milbank Memorial Fund.

This document represents a powerful demonstration of solidarity among thought leadersfrom health plans, physicians, academics, employers, federal payers and consumers on how to make the medical home and ACO support better care forindividuals; foster better health for the community; and help reduce or control costs.

An advance media copy of the report is available for download here.
http://r20.rs6.net/tn.jsp?llr=auyxcvbab&et=1104943619137&s=13773&e=001BPHsLLmMs9bYrh-_8WAmfsK1AhOJrPU1RX1oIcdS1frQyfcJtwRXegLrLAG_g8elwvvl84F105q2kgI2HRdmKKGBpfPcffY0WSFGVM7x0T0O7ISuG0pcttpeT2JFS-SqqJ-yx15KWwGSwNYLDTKZDelalDzPrBPc3mPDQLmZlIzMS9lHZEctzbtLTVUCayU-XV7RombZY6xasDDlxyavknjSjam2_OHstjPSZmeutN2vqK5YMZY921e83n1RFeWtM5SRO8kzo-c=

Better to Best was almost a year in the making and represents collaboration among some of the brightest minds across the public and private sectors. The collaboration culminated ina one-day gathering at a Consensus Meeting hosted Sept. 8, 2010, by the PCPCC and sponsored by The Commonwealth Fund and the Dartmouth Institute.The meeting fostered frank dialogue and robust discussion among its diverse participants-purchasers, providers, thought leaders and consumers of health care. By the end of the day, those gathered arrived at the core areas of consensus illuminated in the report, including:

The goals of both the medical home and accountable care organization are better care, better health and lower costs.

Improvement must be considered both in terms of lower costs and value to the consumer of care.

There is a critical role and need for ongoing reportable measurements that address these goals.

Payment systems need to change and a range of payment models should be tested.

Learning collaboratives and rapid learning environments are needed to establish an evaluation framework around these issues.

Each point of consensus includes specific recommendations and action items around policy, research and features to embed in federal demonstration projects. While some require development of new structures for measurement and evaluation, many build uponexisting efforts, such as aligning future iterations of federal Meaningful Use standards with health IT requirements associated with medical home recognition and future ACO regulations.The group has agreed to continue to work together in support of these shared goals.

The PCMHmodel incorporates the best evidence and the best ideas to drive value in the health care system. But the momentum propelling thePCMH cannot be explained by new ideas or new evidence alone. What is historic is the magnitude of the collaboration, said Paul Grundy, MD, M.P.H., IBM's Global Director of Healthcare Transformation and president, Patient-Centered Primary Care Collaborative.

"It's really powerful. It's the first time there's beensuch a broad agreement on a set of principles. There's an understanding from providers about what they want to provide and a consensus among buyers that they want to buy what the providers are offering," he said."It is a national consensus across the broadest possible range of playerson a journey toward care that's comprehensive, integrated, coordinated and accessible, versus care that's episodic, dis-integrated, uncoordinated, inaccessible."

"With passage of the Patient Protection and Affordable Care Act, we have entered a new era that will ensure health care security for all Americans by improving access, quality and efficiency in our system," said Commonwealth Fund President Karen Davis. "This report indicates that key stakeholders are in agreement on the need to promote patient-centered, coordinated care through changes in the way we pay for and deliver care, and development of medical homes and accountable care organizations are mutually reinforcing models for achieving these goals."

A time for action

Of the four value-driving elements identified in the report, two--enhanced access and care coordination--are elements of health caredelivery that require urgent overhaul to maximize health outcomes at lower costs. The others, health information technology and payment reform, areessential tools, without which widespread implementationof new care delivery models will not succeed.

The questions are: where and when. The answers that emerged from the September 8 meeting are clear: here and now.

Better to Best, and the consensus it reflects, lays the groundwork for achieving the Triple Aim: Improve the health of the population; enhance the patient experience of care; and reduce, or at least control, the per capita cost of care, said co-author Elliott S. Fisher, MD, M.P.H., whose 2006 article introduced the concept of the accountable care organization. "If we remain true to the agreement made in September and formalized in this document, we have the opportunity to help create an accountable, patient-centered system that not only enhances quality of patient care but controls costs."

No longer is health care transformation simply an academic discussion; the evidence of success of the medical home combined with the need for accountable delivery system reform demands action, Grundy said. And *Better to Best* presents a call to immediate action. Just as important, it represents a new covenant between the buyer and provider, he said. "As a result, care is going to be better."

To download a copy of the report, sign up here. Frequently asked questions are answered here.

About The Patient-Centered Primary Care Collaborative

The Patient-Centered Primary Care Collaborative is a coalition of more than 700 major employers, consumer groups, organizations representing primary care physicians, and other stakeholders who have joined to advance the patient centered medical home. The Collaborative believes that, if implemented, the patient centered medical home will improve the health of patients and the health care delivery system. For more information on the patient centered medical home and a complete list of the PCPCC members, please visit http://www.pcpcc.net.

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