Supplemental materials for:

Rollow W, Cucchiara P. Achieving value in primary care: the primary care value model. *Ann Fam Med*. 2016;14(2):159-165.

Appendix

Scenarios in the Use of the Primary Care Value Model (PCVM)

in Primary Care Transformation

Scenario 1

Dr. C is medical director of Coordinated Primary Care, a (hypothetical) community health center. Dr. C develops a plan for meeting Meaningful Use (MU) and PCMH requirements using MU payments:

- **Selection and implementation of an MU-certified EHR** to support documentation, measurement, panel management, point of care reminders, and e-prescribing
- **Development and implementation of practice policies** on access/continuity and culturally/linguistically appropriate care
- **Convening regular practice staff meetings** to discuss performance improvement and engender teamwork
- Implementation of **patient experience measurement**
- Implementation of a **performance improvement process** for clinical and patient experience measures

Two years after plan implementation, the practice has received MU and PCMH recognition, and has realized a small improvement in quality and patient experience measures.

The clinic is proud of these accomplishments, but disappointed with the amount of improvement. Dr. C encounters the PCVM, and implements a second phase of value-focused transformation through:

- **Seeking funding or staff resources for care planning** for high risk patients from Medicaid managed care and commercial payers
- **Identifying community programs** for dietary and stress management (yoga, meditation, and mindfulness) patient self-management support
- **Developing relationships with a community mental health center and county social services clinicians**

Although challenged by the financial and coordination aspects of this phase, Dr. C is encouraged by the resulting improvement in outcomes for the subgroup of patients in care planning.

Scenario 2

Dr. V is director of Visionary Primary Care, a (hypothetical) small practice. Dr. V encounters the PCVM, and is impressed by three things: the need to redesign his practice around patient values, to focus on healing and health through therapeutic relationship and care directed at underlying dysfunction, and to incorporate care planning and coordination with complementary services clinicians in supporting patients.

Dr. V proceeds as follows:

- He **creates a simple survey** that asks patients about what they value: recovery from illness, coping with conditions that can't be cured, optimization of health, relationship with the practitioner, and convenience of care. He samples from subgroups including well, complex medical, and dependent patients.
- Based on survey results, he **creates a redesigned care model**. Initial visits for patients with chronic conditions or wanting to optimize health will focus on relationship, underlying biologic and psychosocial systems, and care planning. Care plans will include

complementary services: dietary, chiropractic/physical therapy, clinical massage, and psychotherapy.

- To provide these services, Dr. V **contracts with a dietitian and massage therapist to see patients in his office**. He will bill for these services, some of which are self-pay. He **develops referral arrangements with a chiropractor and clinical social worker**, whose services are typically covered by insurance payments. He arranges for **referrals to home health/hospice organization** for patients who are not independent, and identifies community organizations and resources who can **provide self-management social services support**.
- He hires **a nurse to do care planning and care coordination**. He identifies health plans that pay for performance and limits her involvement to those, or to patients who can self-pay for health coaching.
- He implements three parallel streams of activity: weekly meetings to discuss changes to patient-centered **culture, practice in teams, performance results and improvement**; acquisition and implementation of an **IT system to support operations and analytics**; and **contracting with payers on a performance basis** and fully developing his **financial model**.

Four years after plan implementation, the practice is growing based on patient referrals, substantial improvements have been documented in self-reported outcome and experience measures, payers tell him that ED and hospital admission rates and costs of care are below average, and he and his staff feel that the practice is meeting the vision that they had when they chose to work in healthcare.