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TO: Dr. Kathleen White, Medical Home Work Group

From: Ben Steffen, Nicole Stallings

Subject: Patient Centered Medical Home adoption from ideas to innovation.

In the next week, we will begin working in smaller groups to develop some core requirements of a patient centered medical home (PCMH) demonstration. The Work Group has agreed to address the development of the Action Plan presented to Council on Health Quality and Cost by forming three subgroups based on convenient breaks in the action plan. The subgroups will work over the next month and we assume 2-3 meetings per group. Subgroup meetings will be via conference call, but we welcome people attending in person (note that members of the public can also dial in or listen). We will use Google Docs as a collaboration tool to share & develop the recommendations. The first meeting of each subgroup is listed below:

- April 24 9:00-10:30 AM - **Medical Home Foundations Subgroup**
- April 27:9:00 10:30 AM - **Practice Transformation Subgroup**
- May 4 9:00-10:30 AM -- **Purchasers and Consumers Education Subgroup**

Note that we will use the (410) 549-4411 call in number for all meetings. The password will be posted at the Medical Home Web Site: <http://dhmh.state.md.us/mhqcc/primarycare.html>.

Each subgroup will schedule its own follow-up meetings. The Work Group as a whole will focus on determining/recommending reimbursement options (Action Item 9) beginning in the early summer.

The **Medical Home Foundations Subgroup** will be charged with addressing the first four steps. This group will balance the 'state of the art' in medical home development with Maryland-specific needs. This group will also consider how a state-wide plan can complement the several single payer demonstrations that are now underway, or in the planning stages, in Maryland. Please refer to Dr. Shematek's recent presentation to the Work Group—he has shared CareFirst's solution to some of

these questions with us. Mr. Eric Sullivan of United Health Care shared with us their approach to some of these same issues in our second meeting. The issues we will need to discuss are listed below:

- Defining the medical home and recognition method – should this be the Joint Principles or a combination of national standards and a Maryland-specific approach?
- Defining participants (types of providers, patients, payers, and purchasers);
- Designating the recognition methods;
- Delineating measurement methods for quality, efficiency, and satisfaction.

The **Practice Transformation Subgroup** will be charged with examining the technical, administrative, financial, and legal issues that would arise if a multi-payer demonstration is established in the State:

- Identifying technical and financial challenges for practices considering adoption of a PCMH model.
- Determining sources of technical and infrastructure support, including foundation, Government, and private.
- Determining the steps needed to sustain PCMHs, once established.
- Identifying legal issues that need resolution, including Medicaid participation, anti-trust and safe-harbor issues.

The **Purchasers and Consumers Education Subgroup** will be charged with developing strategies for involving employers and consumers in medical home demonstrations. This sub group will be:

- Developing purchaser awareness and purchasing strategies.
- Creating standards for a patient education program focused on why it is important to have a medical home and assisting in matching patients and PCMHs.

Future Full Work Group Meetings

We want to alert you to the schedule for future Medical Home Work Group Meetings. We are scheduling four in-person meetings for the Work Group through the summer. Listed below are the dates, times, and main agenda items:

- May 20th, 3:00-4:30 PM, – review of progress of the subgroups
- June 19th 9:00-10:30-- agreements on subgroups' recommendations, begin discussion of reimbursement
- July 17th , 9:00-10:30 reimbursement issues & recommendation discussion
- August 14th ,9:00-10:30 – finalize all recommendations

Discussions of the Principles for Forming Medical Homes in Maryland

Dr. White has requested that we submit a summary of deliberations on definitions, goals, and principles for the patient centered medical home. Presenters have shared their positions and some Work Group members have described their views. We have also pulled material from other PCMH

initiatives around the country. The Medical Home Foundations subgroup will consider these options and bring back to the Work Group recommendations on definitions that we should carry forward.

Definitions of a Patient Centered Medical Home

1. An approach to comprehensive primary care for children, youth and adults—a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient’s family. (Joint Principles, 2007).
2. A personal medical home through which all individuals receive acute, chronic, and preventive medical services through ongoing relationship with a family physician. Patients can be assured of care that is accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians. (AAFP/TransformMED, 2006)
3. A health care setting that facilitates partnerships between individual patients and their personal physicians . . . care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (NCQA, 2008)
4. The medical home . . . is expected to achieve. . . integration and coordination of health care by primary care physicians. . . to enhance patient adherence to recommended treatment . . . avoid hospitalizations, unnecessary office visits, tests, and procedures . . . and use of expensive technology . . .when less expensive tests or treatments are equally effective and [reduce] patient safety risks. (CMS Medical Home Demonstration Design, 2009)

Joint Principles from the specialty societies –

<http://www.pcpcc.net/printpdf/14>

1. Personal physician . . .ongoing relationship, first contact, continuous and comprehensive.
2. Physician-directed medical practice leads a team who collectively takes responsibility for ongoing care.
3. Whole person orientation. . .providing for all the patient’s health care needs, appropriately arranging care with other professionals, care for all stages of life, acute, chronic, preventive, and end of life.
4. Care coordinated/integrated across all elements of the complex care system . . . including, subspecialty, hospitals, home health, nursing homes, community resources, facilitated by registries, information technology, to get patients care when and where they need and want it in culturally and linguistically appropriate manner.
5. Quality and safety. . .support optimal, patient-centered outcomes, defined by care planning, driven by partnership between physicians, patients, family, evidence-based medicine and decision-support tools, continuous quality improvement, performance measurement, patients actively participate in decision-making, and quality improvement at practice, information technology to support care, performance measurement, patient education, and communication. . . voluntary practice recognition, to demonstrate capabilities to provide services consistent with medical home model.

6. Enhanced access to care . . . through systems such as open scheduling, expanded hours, and new options for communication between patients, personal physician, and practice staff.
7. Payment appropriately recognizes added value care management outside the face-to-face visit, separate FFS for face-to-face, coordination of care within a practice and between consultants, ancillary providers, and community resources, adoption and use of health information technology, enhanced communication such as secure e-mail and telephone. . . remote monitoring of clinical data, recognition of case mix differences, allow physicians to share in savings from care management in office, payments for measurable and continuous quality improvements.

Enhancements to Joint Principles

We have discussed and other demonstrations have chosen to add features, change emphasis, or develop different aspects of the Core Principles. These variations represent group's thoughts on enhancements to the general state of the joint principles, including some suggested by the Workgroup. **Ideas discussed in the Work Group are bolded.**

1. **We have discussed the importance of PCMH providing culturally sensitive care.**
2. **Close integration of the PCMH with a network of specialties that come the medical neighborhood for the patient and the PCMH.** (This concept is recognized, but not explicit in the core Joint Principles and is now thought to be critical to the success of a PCMH).
3. Patient-centered engagement and participation in care and decision-making is key to a demonstration. The National Quality Forum explicitly emphasizes listening to “the patient voice” and “organizing around the patient journey” regarding the experience of care across the continuum of care for that person, not just for discrete episodes of care.
4. **Non-physician medical team leadership. Some demonstrations have explicitly recognized the roles that nurse practitioners and physician assistant can serve in leading the medical home care team. The Joint Principles already explicitly recognizes these professionals are part if the team. Although the joint principles have not been changed to recognize a nurse practitioner led team, ACP, one of the signatories to the Joint Principles, has indicated a willing to recognize NP led teams.**
5. **The importance of including Safety net Providers, broad Federally Qualified Health Centers (FQHCs) participation has been recommended within a framework of involving the widest population of patients. These institutions provide a full range of services, fuller than those provided by primary care practices in general. Their more diverse payer mix: private, Medicare, Medicaid, and self-pay, makes adoption of a single payer PCMH model more problematic because of the public payer/higher uncompensated care shares.**
6. Professional education and change management. Many demonstrations recognize the need to

support providers and practices in changing to the medical home model, but some are more explicit about the kinds of training required. Others emphasize change management, leadership development, or learning collaborative far more than others.

- 7. Primacy of Chronic Care Model. While improving chronic care is explicit or implicit in most demonstrations, there are differences in how prominently medical home design features, or is based on, the Wagner Chronic Care or Planned Care Model.**
- 8. Practice-based care management.** Care management, care coordination, or case management is prominently featured in demonstrations; however, differences in meaning among these three terms tend not to be spelled out. In addition, how broadly care coordination is to take place across the continuum of care to include inpatient, nursing homes, rehab facilities, public health and community resources tends not to be spelled out.
- 9. Behavioral health integration.** Demonstrations usually mention medical and behavioral care, but some emphasize this far more than others. In Maryland, we have not discussed this integration.
- 10. Participation of pediatric practices again with the goal of including the widest range of practices possible.** Pediatricians were at the forefront of designing and implementing medical homes specifically for special needs populations more than 40 years ago. In most demonstrations, pediatricians are not specifically excluded from demonstration, although a scan locally and nationally indicates that their participation is rare. Some payer-lead PCMH demonstrations have difficulty developing a reward structure that is attractive for pediatricians.
- 11. Multi-stakeholder, multi-payer engagement.** Broad stakeholder engagement is critical for PCMH formation, but some are much more clear than others on just what this means and how collaborative processes or convening skills are deployed to make joint efforts across providers, payers, employers, patients, and government programs truly productive and successful.
- 12. Medical home practice recognition.** Almost all papers and demonstrations point to the need for practices to become truly capable of functioning as medical homes in order to reap the benefits, and most of these point to the NCQA PC-PCMH criteria tool. Others point to alternatives, such as the AAFP/TransforMED criteria, the CMS Medical Home Demonstration criteria (a 2-level variant of the NCQA recognition tool), health plan criteria, or the possibility of other consensus based tools. A question for Maryland will be how explicit to be in the certification tools and process.
- 13. Espousal of payment reform.** All papers and demonstrations point to payment reform that rewards primary care work beyond face-to-face visits or procedures, typically adding a bundled care management fee of some kind and some form of pay-for-performance bonus. While these are common themes, there are significant differences in payment model specifics and levels of development.

14. More explicit delineation of payment. Some call for medical home payment to appropriately recognize added value, including allowing physicians to share in savings from care management in office. Other payments are for measurable and continuous quality improvements and direct payments for MEANINGFUL use of information technology related to the PCMH . The health EHR bill recently passed by the Maryland General Assembly provides for these types of incentives.

End Notes:

Sections above are discussed in 'Evaluation and Performance Management' accessible at http://healthvermont.gov/prevent/blueprint/documents/AHRQ_evaluation_recommendations.pdf and 'Statewide Provider Practice' accessible at <http://healthvermont.gov/prevent/blueprint/documents/blueprint-MDworkplan.pdf>,

"Task 2 Report on the Current "State of the Art" for Medical/Health Care Home" from Minnesota accessible at: Http://www.icsi.org/health_care_redesign_/health_care_home_/health_care_home_outcomes_reports/