

Medical Home Advisory Council Meeting  
January 5, 2010  
LMEP, Room 1

In attendance: Dr. Woodruff, Dr. Hickey, Sen. Gloor, Dr. Werner, Dr. Knowles, Dr. Wergin, Dr. Carnazzo, Dr. Darst

DHHS staff in attendance: Aishah Witte, Jenifer Roberts-Johnson, Roberts-Johnson, Pat Taft, Margaret Brockman

#### Approval of December 2 Meeting Minutes and Approval of Agenda

Dr. Werner called the meeting to order at 1:11. The minutes were approved without revision. Dr. Werner called for comments and revisions on the proposed agenda. There were no comments or changes and the agenda was approved.

Dr. Werner started the meeting by saying that the Council has spent a lot of time talking about how they want to do things from a philosophical standpoint and it is now time to start talking to people with the expertise needed to help them move forward.

#### Set Future Meeting Dates

Dr. Werner asked the Council to set the next two meeting dates. It was agreed that the Council would continue to meet the first week of each month on alternating Tuesdays and Wednesdays. The next meeting dates were set for March 2, 2010 and April 7, 2010.

#### Discuss Content for February Meeting with Michael Bailit

Dr. Werner advised the group that their conference call with TransforMED would start at 1:30 and they could work through the agenda items until the conference call began. He asked for a brief discussion on the subject matter and questions for the call.

Ms. Taft explained that Michael Bailit, national expert on medical homes, will be joining them for the February meeting to primarily discuss payments but could address other subjects. She asked for questions and topics the Council would like to discuss.

The following questions and topics for the Bailit visit and this conference call were identified:

- Is there a type or size of practice that is more successful? (Dr. Wergin)
- What type of sample size is needed to measure success? (Dr. Knowles)
- How you do define/set achievable goals for the practice sizes that will be participating in the pilot? Additional information on sample sizes. (Dr. Knowles)
- What makes a medical home pilot financially attractive to the practice and what thresholds should be set? (Dr. Hickey)

- If a guarantee is made in terms of compensation, how could it be funded through a public entity? (Dr. Hickey)
- What kind of barriers exist when public and private projects interface? How do you go about building this type of partnership given that the Nebraska project would like to partner up with BlueCross BlueShield? (Dr. Wergin)
- Is it beneficial to define practices by the use of a specific EMR instead of geographical locations? (Dr. Werner)
- What are the characteristics of a practice that will be successful? (Dr. Werner)
- What do they see coming out Washington, DC for Medicare? What guidelines are set up in this multi-payer concept for combined pilots? More information about Medicare pilots in general. (Dr. Hickey)
- How broad or loose do you set the criteria and outcomes? Should the Council be very narrow in their approach or just look at diabetes or other easy markers? (Dr. Wergin)
- Do they use an effective well-being tool? Existing tools seem to be for assessing practices and not assessing patient health or their feelings toward their physicians. (Dr. Hickey)

#### Finalize Recommendation for Pilot Objectives

Dr. Werner asked the Council member to finalize the pilot objectives. Pat Taft read the legislation over for everyone and discussion ensued. Dr. Darst pointed out the need to include language that creates a clear understanding that one of the objectives of the pilot is to specifically promote the physician's satisfaction and reward their efforts.

The discussion broke for the conference call at 1:33 p.m. It was picked back up after the conference call and ensuing follow-up discussion.

Dr. Woodruff brought the discussion back to the physician component. Dr. Carnazzo upheld this notion remarking that the doctors may end up working harder while being paid less for their efforts at least initially but there will be enhanced quality of care and patient/physician satisfaction. Dr. Darst suggested the wording "promote the pleasure of providing primary care." Sen. Gloor told the Council that one of the driving reasons he introduced the bill is that a lot of money is put into loan forgiveness and other efforts but something needs to be done to enhance the experience for the primary care physician. Dr. Werner suggested the following, "enhance the satisfaction, fulfillment, and status of primary care practices."

There was also a discussion on the payment methodology related objective. Margaret Kohl questioned whether the use of the word clinical excluded the social coordination aspect of the pilot. Dr. Darst said that in his mind, the word clinical is all-inclusive. Dr. Woodruff expressed agreement.

The objectives were finalized as :

- Align the payment methodology to the clinical practice of medicine;

- Institute a team model approach to patient care to improve quality, safety, access, and health outcomes;
- Serve as a basis for future projects; and
- Enhance the satisfaction, fulfillment and status of primary care practices.

**MOTION: Dr. Woodruff moved to adopt the objectives as written.** Dr. Wergin seconded. Voting yes: Carnazzo, Darst, Hickey, Knowles, Wergin, Werner, Woodruff. Voting no: None. Abstaining: None.

CONFERENCE CALL: Dr. Terry McGeeney, CEO, TransforMED, *Medical Home: What Works and Lessons Learned*

Ms. Taft reported to the Council that TransforMED has offered the use of their Delta Exchange and online assessments tools including a tool that assesses practices readiness to be a medical home at not charge. Dr. Wergin noted that they follow the NCQA standards.

The call started with introductions around the table. Attending from TransforMED were Dr. Terry McGeeney, CEO, Elaine Skoch, Vice President for Performance Improvement, and Dan McKean, Business Development.

Dr. McGeeney, spent 13 years in a solo rural practice and another 13 years in a multi-physician group. His current academic employment is at the University of Kansas. TransforMED is a subsidiary of the AAFP and they have invested millions in TransforMED to further medical home initiatives. TransforMED has an arms length relationship with AAFP and well funded. They are able to provide expertise and resources to support transformation to a patient-centered medical home. TransforMED had a private academic evaluation that finished a year and a half ago, the report is being printed and should be available soon. They are currently working around the country on a number of single payer pilots and are involved with two large multi-payer pilots.

Dr. McGeeney reported that a pitfall of many Medicaid pilots around the country is that they focused too much on chronic disease without really making the changes needed at the practices such as creating electronic disease registries, implementing team care approaches, etc. He reporting having read the Nebraska legislation and sees the Nebraska pilot as having a much broader vision than just chronic diseases. He believes the Nebraska legislation was well written.

Dr. McGeeney stated that TransforMED staff is comprised of nurse practitioners, Six Sigma Black Belts, and others with senior management experience. They use a facilitative approach as well as a collaborative meeting model. They bring in physicians from other markets to share their experiences and institute a learning community. Their contact with the pilot projects is increasingly virtual using their Delta Exchange, a social networking technology. They set up private zones for different pilot projects and host webinars allowing them to cast a broader net relatively inexpensively. He reported that TransforMED would be doing free education for CMS via webinars and collaborative

meetings. TransforMED also has web-based pod tools including a real time patient experience tool.

Every project has some unique attributes and Dr. McGeeney does not believe that a boilerplate for a medical home can be created. He reported that they assist projects in the application processes to establish the location of the medical home pilot where the sponsoring organization can set up scoring tools to assess the practice's level of medical home readiness. They also have a tool to assess what the practice's NCQA score might be in addition to leadership assessment, change readiness, and HIT tools. TransforMED can provide free assistance and then go into the practices, visit them, and create a timeline for transformation. Depending on the sophistication of practices, Dr. McGeeney said that implementation could occur relatively quickly. He said they could provide quarterly reports on the progress of the practice and promote registry tools. He hopes the State can provide a registry tool for the practices.

TransforMED concentrates their efforts on team care coaching, care management, care coordination, e-prescribing, and EMR selection. They promote spending as much time as possible with the patient, which really does work. They are working with more internal medicine practices (60%) and had a number of pediatric practices join. The diseases may vary but the problems and the processes all the same for the different practices. He reported that the TransforMED model is very structured and the evaluation is very involved. Staff in the practices are overwhelmed at first but afterwards doctors see the benefits and are happy to be spending more time with their patients. TransforMED has a defined process for educating doctors, rewarding them, and providing them with tools such as registries.

Dr. McGeeney reported that he felt TransforMED could greatly accelerate the Nebraska pilot start date from the required 2012 date in the legislation. He feels that the savings to the Medicaid program can be tremendous especially for the high need, high utilizer patients. Dr. McGeeney then opened up for the floor for questions.

Dr. Werner asked how to measure success from a clinical and financial side and for guidelines on a successful transformation given that the Council has to report to the legislature. Dr. McGeeney responded by saying that TransforMED uses consistent dashboards and metrics across all projects. There needs to be measurement of how far the practice has come. The two outcome measures are quality and efficiency. For standard diseases and immunization, score quality metrics by percentage of improvement or hitting quality numbers. The practice may already be doing well and will need to be rewarded for hitting milestones. There needs to be some mechanisms in place for identifying non-compliant patients and a structure for rewarding the efforts of the practice. Efficiency can be measured in the number of ER and hospital visits in addition to percentages of generic drug use. Per Member Per Month (PMPM) fees and rewards systems are implemented from there.

Dr. Hickey asked about impressions of health and well-being tools. Dr. McGeeney reported having a tool that patients take after each visit that is the patient's opinion of the

performance of the medical home and their own well-being in relation to the performance of the practice. The tool provides feedback to the practices on how patients perceive their experience. Dr. Hickey and Dr. McGeeney then discussed that they were unaware of tools that have gone through validity testing and there was not much work being done nationally in this regard.

Dr. Werner asked for guidelines on picking low-hanging fruit and guidelines for picking a practice. Dr. McGeeney recommended selecting a practice with an EMR in place. The practice will do a better job with care management, care coordination, and be able to capture data more readily. He also recommended ensuring that the practice has the capacity to change and the appropriate leadership entities are on board with the changes. Significant percentages of Medicaid patients are also important so there is enough incentive to affect change for all patients.

Dr. Hickey asked Dr. McGeeney to talk about what opportunities are present in pending federal legislation for collaboration with Medicare. Dr. McGeeney reported that there are two pilots of interest. Around 8 states and 450 practices with care management fee levels of three and four are slated for participation in the first. It is currently on hold and waiting to get through health care reform legislation. The second one was announced by Kathleen Sebelius in late November, early December. The pilot must be by a state agency and must be ongoing at the time of application. There are not many states with Medicaid pilots ongoing. Dr. McGeeney thought that Nebraska may have an advantage with this second pilot, as Nebraska will be able to demonstrate meaningful activity especially given that the legislation was approved prior to the Sebelius announcement.

Dr. Hickey and Dr. McGeeney then discussed names of possible contacts at CMS.

Dr. Wergin expressed concerns with the NCQA standards and getting the practices to buy-in to the medical home concept. Dr. McGeeney discussed his concerns with the NCQA standards as well. The standards do not measure quality but TransforMED has alternatives. He expressed caution in providing practices with money up front. Offering help in setting up their patient registry is a recommended incentive as well as offering to help the practices transform with rewards provided incrementally along the way. Sharing a percentage of the savings with the practices is also recommended. Physicians generally want to do the right thing and if you give them the resources, they will do the right thing.

Dr. Hickey asked about practices with cash flow issues and whether or not to pay a care management fee. Dr. McGeeney recommended paying a PMPM once the practice becomes a medical home and increasing the fee as the practice reaches different levels. Dr. Werner inquired about PMPM fees nationwide. Dr. McGeeney said that they are between \$3.00 and \$5.00 but something like \$10.00 makes more sense for the Medicaid population. He then reiterated the benefits of offering a technology incentive up front and rewarding the practice with the PMPM when they actually become a medical home.

Dr. Hickey asked about incorporating social support organizations. Dr. McGeeney recommended leveraging internal resources in the practice and external resources to

identify the high utilizers and look at ways to approach them differently and more effectively.

Dr. Werner asked again about selecting practice sites and the factors that may be important to consider in selection such as rural vs. urban and the existence of an ER in the community. He asked about the concept of a pilot with practices using the same EMR but not located in the same geographical location. Dr. McGeeney said this was a concept they had considered before but with the national movement towards accountable care organizations and the emergence of interoperability tools on the market from the AMA and IBM, having the same EHR is less important because any EMR will likely allow the data to be collected and put into a central repository for reporting. He said that if they use the same registry, do not need the same EHR as those can be connected. He reported that the existence of an ER is not necessarily so important but a good working relationship between the doctors and the ER is something that can affect success of the pilot.

Discussion ensued on the differences between a small town ER and one in an urban area. Out of this discussion, Dr. Werner asked Dr. McGeeney to talk about examples of patient care management and the components of an effective doctor-ER working relationship. Dr. McGeeney talked about having a letter of agreement with the ER and the hospitalists requiring them to refer patients back to their primary care physician within two days, providing useful reports back to the primary care physicians in a timely manner, and involving the primary care physicians in advanced imaging and other major decisions. He mentioned that JCAHO would be starting to score coordination of care back to primary care office.

Dr. Werner asked about the practices that essentially went bankrupt and what pitfalls to avoid. Dr. McGeeney noted that the two practices with issues were unique situations including a doctor who made some poor financial decisions up front and another where there were issues with the hospital association funding.

Dr. Darst asked what are the first three things the Council should tell the doctors when they approach them about doing the pilot. Dr. McGeeney recommended not telling them anything but have the practices take the assessments on leadership and then work together with the practice to develop a timeline for implementation. Communication, effective change management, and sound leadership are key factors. Dr. Darst and Dr. McGeeney both noted that it might be politically best to cast a wider net and have twenty or so practices take the assessments, then choose the higher performing practices from there.

In closing, Ms. Taft stated that the Council will be discussing TransforMED's offer to try out their Delta Exchange service and possibilities for use of the online assessment. Dr. Hickey asked for help in making connections with folks in Washington who will be able to assist Nebraska with future funding opportunities.

The call closed at 2:39 p.m.

In discussion of the call, the Council decided they would like some time to digest the information received and discuss next steps from there. An index of TransforMED services would be helpful. Dr. Hickey noted that regardless assistance from TransforMED would help Nebraska to avoid mistakes made by others. Ms. Roberts-Johnson stated that if the Council decides to seek further assistance from TransforMED beyond the free tools they offer, Ms. Taft would look it into this.

Near the end of the meeting, the Council voted on pursuing their relations with TransforMED.

**MOTION: Dr. Wergin moved that Council further explore the possibility of a relationship with TransforMED.** Dr. Darst seconded. Voting yes: Carnazzo, Darst, Hickey, Knowles, Wergin, Werner. Voting no: None. Abstaining: Woodruff (who excused herself early from the meeting).

#### Review Outcomes from Last Meeting

Outcomes discussed at the December 2 meeting will be further reviewed at a future meeting.

#### Discussion: Practice Standards

Dr. Woodruff suggested tapping into federal funds to help with the implementation of the EMR as an incentive for the selected pilot site. Ms. Roberts-Johnson discussed specifics on the federal money available for EMR implementation. Dr. Knowles expressed concern in working with a practice that was just implementing their EMR because the EMR alone is such a huge change. She noted that the fact that a practice has implemented an EMR successfully would show that the practice had the leadership infrastructure in place to be a good candidate for the pilot. The characteristics of a desirable practice were discussed in more detail. Further discussion was tabled for a future meeting.

#### Review of Data and Establish Criteria for Pilot Geographic Area

Ms. Roberts-Johnson presented the data handouts provided to the group. The data handouts included the numbers associated with the Enhanced Care Coordination initiative, number of eligibles by county with new percentage breakdowns, and age breakdowns for the AABD population. Dr. Werner asked Ms. Roberts-Johnson what stood out for her in looking at the data. She referred to the visits per eligible information and noted that York, Otoe, Dakota, and Dawson counties had high numbers. Dr. Woodruff proposed looking at Lincoln county as a place where the pilot could have an impact but does not know if they have an EMR in place. Dr. Carnazzo was in favor of picking sites based on the existence of an EMR and number of Medicaid patients then using the assessments to narrow it down from there.

Ms. Roberts-Johnson led discussion on the RFI process. The RFI process is open to everyone and desirable practice sites could be encouraged by Council members to participate in the RFI. Ideas were provided to Ms. Taft on what should be included in the RFI. Ms. Taft will prepare a draft RFI for the Council's review. It was also noted that Ms. Taft has prepared a timeline with recommended dates for site selection and the other important milestones. Dr. Werner advised having the RFI process completed by summer.

Dr. Carnazzo addressed whether or not any of the practices with doctors on the Council should be excluded. Sen. Gloor advised that they would at least not be able to vote on site selection.

### Other Items Discussed

Dr. Woodruff commented that savings could be recouped more quickly if the pilot was implemented more quickly than anticipated with the assistance of the TransforMED. Sen. Gloor said that the reality is that the full two years may be needed but his hope is for sooner. He reported that the Medicaid program was initially willing to absorb the pilot within their operating budget and it is not known at this time to what extent the program will be able to fund this. The Council needs to develop their plan and then they will be able to go back and make a case for the funds needed.

Dr. Wergin and Dr. Hickey discussed connections they have made and would be open to pursuing further with key players in other high profile national pilots and with BlueCross BlueShield. Sen. Gloor commented that contacts from this committee should go through Medicaid to avoid political issues even just as a touch base.

The goal and nature of the desired relationship with BlueCross BlueShield and other players was discussed. It was noted BlueCross BlueShield's pilot might be more of a disease registry than what the Council is envisioning for Nebraska's pilot. Dr. Werner and Ms. Roberts-Johnson suggested that the Council appoint two representatives to connect with these outside players in conjunction with Director Chaumont and the Medicaid program.

**MOTION: Dr. Carnazzo moved that the Council appoint two representatives, namely Dr. Hickey and Dr. Wergin to represent the Council in discussions with Blue Cross BlueShield.** Dr. Woodruff seconded. Voting yes: Carnazzo, Darst, Hickey, Knowles, Wergin, Werner, Woodruff. Voting no: None. Abstaining: None.

Sen. Gloor brought up the concerns with anti-trust issues. Ms. Roberts-Johnson stated that GPRO should also review the attorneys' opinions as to how the Medicaid program will proceed from a policy perspective. Sen. Gloor offered his assistance in this matter.

The possibility of participation in the Medicare pilots was discussed. Dr. Hickey noted that even if Nebraska does not directly meet the criteria for the proposed Medicare multi-payer pilots, seeking out informal ways to garner funding would be beneficial. Even just

getting Nebraska's name out there is important because they need success as much as Nebraska does.

Conclusion

Dr. Werner called for any public comments and there were none. The meeting adjourned at 4:30.