

Medical Home Advisory Council Meeting  
March 2, 2010  
LMEP, Room 1

Members in attendance: Dr. Werner, Dr. Darst, Dr. Carnazzo, Dr. Knowles, Dr. Wergin,  
Dr. Hickey

Members not in attendance: Sen. Gloor, Dr. Woodruff

DHHS Staff in attendance: Aishah Witte, Pat Taft, Margaret Brockman, Jenifer Roberts-  
Johnson, Paula Hartig, Heather Leschinsky

#### Approval of February 2nd Meeting Minutes and Approval of Agenda

Dr. Werner convened the meeting at 1:17 pm. He called for corrections to the February minutes and they were approved as written. The agenda was also approved as written.

#### Staff Update

Ms. Roberts-Johnson informed the Council that the first two objectives identified by the Council were adopted by the Division of Medicaid and Long-Term Care because they aligned with the legislation as written. The second two objectives that related to future projects and enhanced satisfaction were not adopted because these topics were not included in the legislation.

Ms. Roberts-Johnson relayed to the Council that funding was made available in the Medicaid budget totaling \$530,000 for the pilot start up costs. Staff created a start up budget including administrative costs for an evaluator consultant, training for practices, stakeholder meetings, changes to Nebraska's MMIS to accommodate payment, and facilitators to help with practice transformation, and continued practice coaching.

A discussion followed on how future changes in payment methodology would be handled by Medicaid. Ms. Roberts-Johnson noted that the payment change would not occur until the next two-year budget so accommodations could be made as needed but relayed that payment changes could occur without budget changes. She confirmed that legislative changes would not be needed for changes in reimbursement but NE Medicaid would need to work with CMS for approval of the changes.

Ms. Roberts-Johnson addressed the concerns with anti-trust issues. She stated that Medicaid's legal counsel did not see any concerns as long Medicaid worked only with one other commercial payer.

Ms. Roberts-Johnson reported that the Division has enlisted the help of a statistician in Public Health for determining what population numbers would be recommended for the pilot. The statistician and DHHS staff are looking at what the numbers would be at a

reasonable confidence interval for evaluation, somewhere above 85%, instead of what the statistically significant numbers would be for a research based pilot. A brief discussion followed on the number differences to attain statistically significant change from a clinical perspective vs. a financial perspective.

Ms. Roberts-Johnson reported that the meeting with Dr. Bill Minier and Dr. Dave Filipi from BCBS has occurred and they are very interested in collaborating with Medicaid on this pilot. Dr. Wergin, Dr. Hickey, and Director Chaumont attended the meeting. BCBS will provide information about their penetration rates and they lent the idea of allowing use of their MDdatacor health product for health management purposes to the participating practices. The practices can submit their claims data and the MDdatacor tool will crunch the numbers for them. Dr. Wergin noted that the tool is even able to extract data from dictated notes. BCBS also talked about contributing staff resources to the pilot. Ms. Roberts-Johnson reported that we are now waiting for contact information from BCBS to move forward.

Dr. Werner asked about the Medicare partnership timeline and Ms. Roberts-Johnson stated that it is still a possibility but does not believe Nebraska meets the requirements yet but could look at applying when the demo RFP is released by CMS and criteria has been changed.

#### Discussion: Pilot Timeline

Ms. Taft presented the most current draft timeline. The Council members felt that a year of support to the practices before transformation was too long of a timeframe. Dr. Knowles recommended three to six months be allotted so the practice does not lose their enthusiasm and focus. Dr. Hickey shared that Alegen Health is working on a one-month timeframe for implementation in five member practices. Dr. Darst reiterated the importance of selecting a practice that will adjust easily to change and also noted that the physicians need to be geared up to do something new as well so their enthusiasm and commitment can filter down throughout the practice. Ms. Taft reported that she would revise the implementation time to six months and this timeframe could be re-assessed after the practices have been selected. There was a preference discussed for shortening the timeframe even further down to three months but the Council decided against this after discussing that too short of a time period might also discourage participation up front.

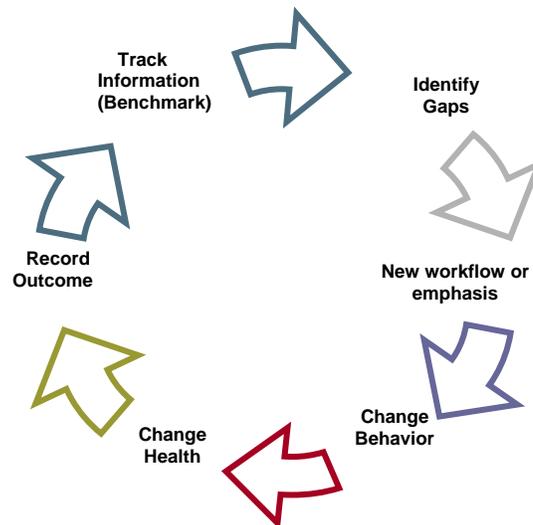
Ms. Taft asked the Council to send her any additional comments they may have after further review of the timeline by email, adding that the timeline is not set in stone and fluid.

#### Discussion: Core Competencies

Ms. Brockman presented assorted core competencies lists compiled by the DHHS Standards Resource Team. She reported that the Team's recommendation is to create a homegrown tool incorporating what they liked from the NCQA list as well as the lists

from other states instead of simply adopting one of the existing lists. She also noted a preference for using the term “core competencies” instead of some other wording as some states may be using slightly different language in this regard. Further breakdowns of the core competencies list done by team member, Margaret Kohl were provided to the Council as starting points for further discussion. Dr. Werner called for the Council to determine what the six or so important items are and the Team could work on providing breakdown information for those items.

The Council went on to discuss which items they felt were essential and identifying those that were easily agreed upon. Much discussion centered on the headings of quality improvement and information tracking including what all those items encompass. Dr. Darst drew chart below on the whiteboard as a part of this discussion:



The Council discussed the meaning of patient centered care and liked the term Coordinated Patient Centered Continuous Care. Cost effectiveness was discussed and a preference toward the term care efficiency was indicated. There was discussion on whether accessibility means extended hours or if it refers to the relationship with and specific accessibility of the primary physician.

The following core competencies were identified and agreed up on by the Council:

- Ongoing patient relationship with physician in a patient directed team
- Quality improvement
- Coordinated Patient-Centered Continuous Care
- Care Efficiency
- Accessibility

#### Discussion: Pilot Outcomes

Heather Leschinsky and Paula Hartig from the DHHS Evaluation Resource Team presented data compiled on population numbers. Based on their initial research work,

300 patients is a proposed pilot number. Ms. Hartig laid out the three primary outcomes in the legislation to use as the outcomes to measure for the pilot. These outcomes were improved access, improved outcomes, and containment of costs to the medical assistance program. Ms. Hartig started with a literature review and then worked on determining how to get the data needed to measure the success of the outcome measures. She recommended use of the Clinician Group CAHPS survey tool for patient experience data, the SF36 tool for health outcomes data as well as tracking wait times for appointments, total number of clinic hours, and hours outside of routine hours.

Ms. Leschinsky clarified for the Council that it would not be recommended to establish outcomes that are different from the core competencies. Once the Council decides on the pilot outcomes, the Team will propose measures for the Council to consider.

Dr. Hickey asked if there would be a control population and Ms. Hartig responded that the current thinking is to have the studied population be its own control. Discussion continued on this topic as well as on the difficulty of showing financial savings and if there were any other possible outcomes to measure. Physician and practice satisfaction was identified as a possible outcome.

The measurement tools and their merits were discussed. The group also discussed whether to measure something that may not improve.

The Council determined that these would be the recommended pilot outcomes for measurement:

- a) Improve health care access
- b) Improve health outcomes for patients
- c) Contain costs in the Medicaid program
- d) Measure patient satisfaction
- e) Measure practice satisfaction

**MOTION: Dr. Darst moved to recommend the discussed core competencies and pilot outcomes..** Dr. Knowles seconded. Voting yes: Carnazzo, Darst, Hickey, Knowles, Wergin, and Werner. Voting no: None.

#### Set Future Meetings

The April meeting will stay as scheduled for April 7 and the May meeting was scheduled for the 11<sup>th</sup> from 1:00 p.m. to 5:00 p.m.

#### Public Comment

There were no members of the public present to provide comment.

Dr. Werner adjourned the meeting at 4:43 p.m.