

Planning a Medical Home Initiative: Recommended Design Steps

February 3, 2010

Presented by Michael Bailit to the
Nebraska DHHS Medical Home Advisory Council

bailit
health
PURCHASING

Medical Home Pilots in the United States

- There are a large number of medical home pilots and demonstrations currently underway – at least 27 were as of 10-09 according to the Patient-Centered Primary Care Collaborative¹, with many more in development.
- A number of multi-payer pilots (CO, NY, PA, RI and more), since it is hard for a single payer to fund the practices alone & make it meaningful for the practices.
- While there are commonalities across these multiple efforts, they also differ from one another in important ways. These differences become most apparent as the pilots and demonstrations move from concept to implementation.

1 “Proof in Practice”, Patient-Centered Primary Care Collaborative, October 2009. Available at www.pcpcc.net.

Recommended Medical Home Initiative Design Steps

- Planning a medical home initiative requires:
 - sequenced design making in critical design areas, moving to ever-increasing levels of specificity, and
 - iterative discussion, in recognition of both the interdependencies of the design decisions and the inevitable stumbling blocks that can be resolved only through repeated consideration and, sometimes, negotiation.
- To make the design process both efficient and effective, it can be helpful to identify the critical design areas and organize design work around those topics.

Recommended Medical Home Initiative Design Steps: Critical Design Areas

1. Defining your medical home
2. Supporting practice transformation
3. Reforming payment
4. Engaging patients
5. Soliciting and selecting practices
6. Evaluating impact

Defining Your Medical Home

- The “Patient-Centered Medical Home”, or “Medical Home”, is a collection of processes implemented by primary care practices.
- Each Medical Home initiative decides which processes it wants to adopt, and of those, which it wants to emphasize. As a result, not every medical home initiative, let alone every medical home, is alike.
- Overlapping but differing takes on medical home include...
 - TransforMED
 - NCQA PPC-PCMH standards
 - Chronic Care Model

Defining Your Medical Home

- Examples of different areas of emphasis:
 - THINC RHIO (Hudson Valley region of New York)
 - Views EMR and HIE connectivity as prerequisites to medical home adoption and operation
 - Supplemental payment tied to NCQA recognition and to performance re: P4P metrics
 - QIO provision of practice transformation support
 - Pennsylvania Chronic Care Initiative (Northeast Region)
 - Practices required to have patient registry functionality
 - Two PMPM supplemental payment streams, one tied to practice-based care management. Also, shared savings for practices.
 - Chronic Care Model emphasis with NCQA recognition required by month 18, but not a prerequisite for supplemental payment
 - Learning collaborative and practice coaching, with data feedback

Defining My Medical Home

- ✓ Personal clinician
- ✓ Patient-centeredness
- ✓ Team-based care
- ✓ Proactive planned visits instead reactive, episodic care
- ✓ Tracking patients and their needed care using a patient registry
- ✓ Coordinated care across all settings
- ✓ Integrated care management
- ✓ Support for self-management of chronic conditions
- ✓ Enhanced access

Defining Your Medical Home

- How to decide upon your definition?
 - Solicit opinion
 - Consider available research literature
 - Consider what will be necessary to:
 - Produce superior primary care and generate improved patient outcomes
 - Support sustainability and spread (e.g., short term return-on-investment)

Supporting Practice Transformation

- True practice transformation is hard work – almost always more so than what practices presuppose.
- Medical home initiatives across the U.S. have taken different approaches to support practice efforts at transformation. These approaches fall into four categories:
 - Self-teaching incentive
 - Practice coaching and/or consultation
 - Learning collaborative
 - Combination of approaches

Supporting Practice Transformation

- **Approach #1: Self-Teaching**
 - Example: THINC RHIO
 - Practices are required to become NCQA-recognized as a PCMH in order to qualify for enhanced payments.
 - Practices must also implement a CCHIT-certified EHR that interfaces with the regional HIE, and must perform at a specified level for 10 HEDIS measures.
 - Strengths: Requires provider “skin in the game”; requires little training investment by sponsors
 - Weaknesses: Assumes NCQA recognition equates to medical home adoption; favors larger and better capitalized practices

Supporting Practice Transformation

- **Approach #2: Practice coaching and/or consultation**
 - Examples: Horizon Blue Cross/Partners in Care (NJ), Texas Medicaid and UnitedHealthcare AZ pilot
 - *Horizon*: provider Management Services Organization provides consultative support to member practices
 - *Texas*: State will provide practice coaches who will teach the participating practices to master six core competencies
 - *UnitedHealthcare*: funding TransforMED “Practice Enhancement Facilitators” to consult to practices on transformation
 - Strengths: Provides targeted instruction to practices
 - Weaknesses: Heavily dependent on the skills and personalities of the practice coaches; physicians may give less credence to nurses than to peer physicians

Supporting Practice Transformation

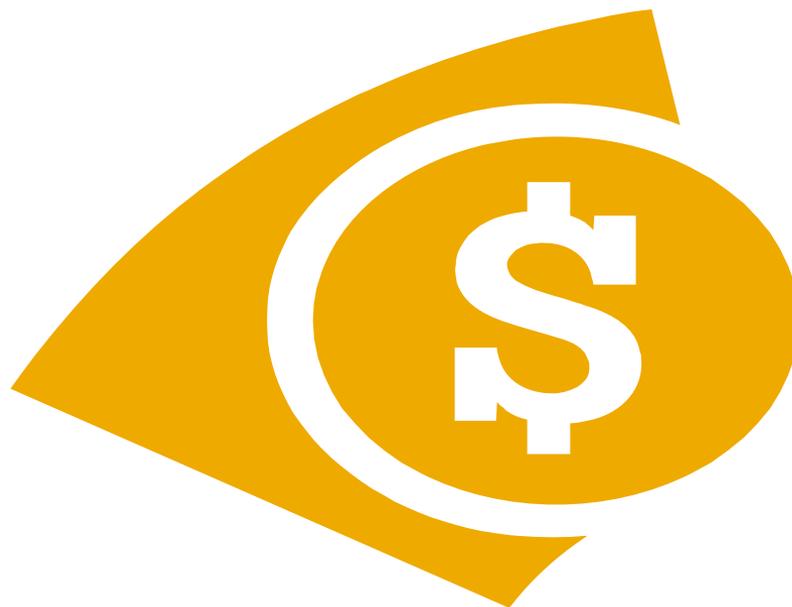
- **Approach #3: Learning Collaborative**
 - Examples: Washington State Department of Health and academic medical center collaboratives sponsored by AAMC
 - Using the IHI's Model of Improvement, typically involves four sessions and a total of seven days over a course of 12 months. Can extend longer, however.
 - Strengths: Intense learning experience with peer practices and at least some physician faculty can be effective at engaging the practices
 - Weaknesses: Logistically complicated; if poorly executed will lose physician commitment; high cost to practice in terms of lost office time unless time is compensated

Supporting Practice Transformation

- **Approach #4: Combination of Approaches**
 - Examples: CO, PA, RI and VT all offer learning collaboratives and practice coaching, and require NCQA PCMH recognition
 - There are differences, however, in terms of learning collaborative duration, focus of collaboratives, NCQA requirements and timing, and source, duration and supply of practice coaching
 - Funded by grants, states and payers in different combinations
 - Strengths: Comprehensive supports may make the challenging transformation process more likely to succeed
 - Weaknesses: This is the most complex (and costly) of the four identified approaches

Reforming Payment

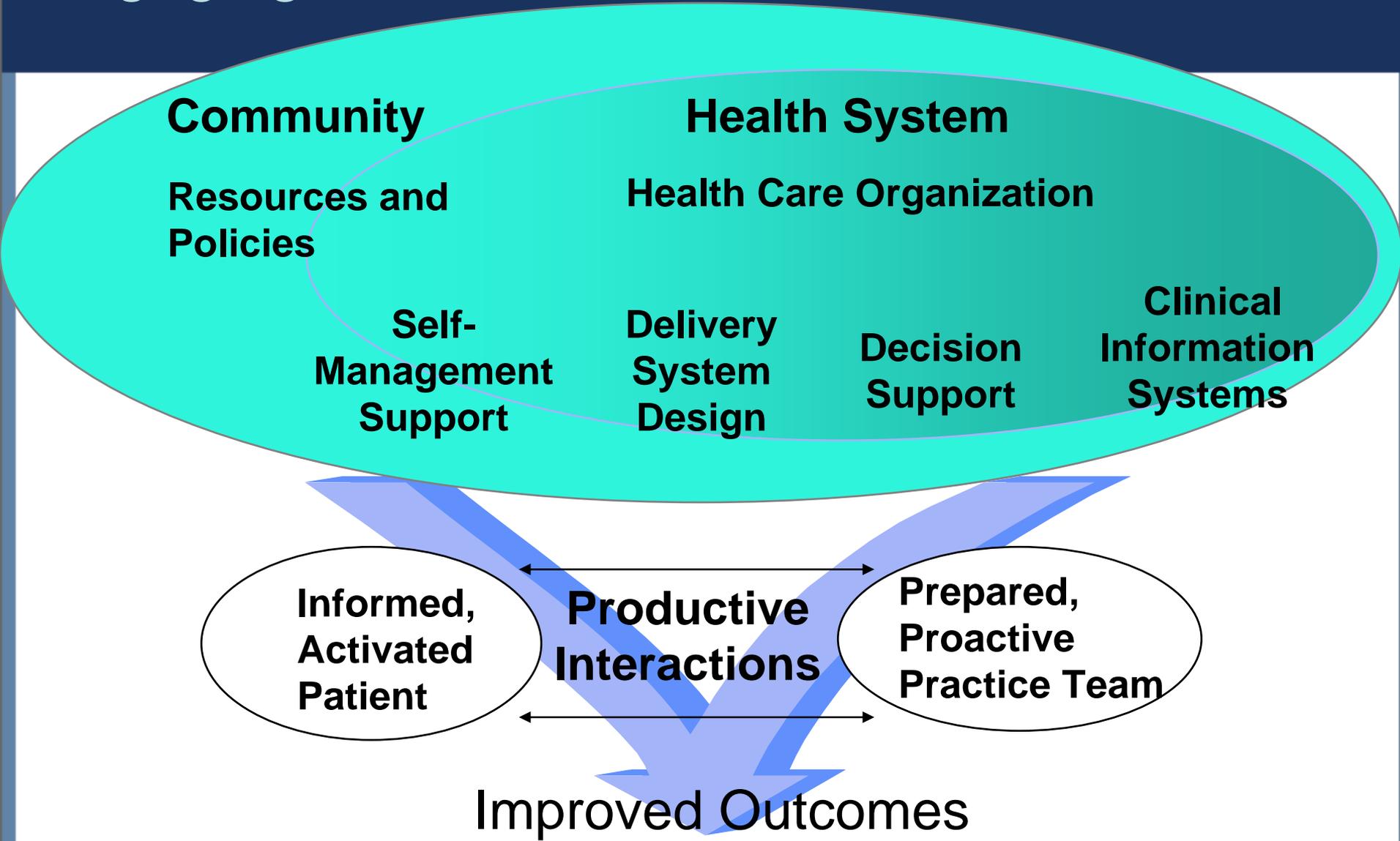
- This topic will be discussed separately later in the afternoon.



Engaging Patients

- While patient engagement is a critical element of the antecedent Chronic Care Model and of the Medical Home, it receives limited attention in many demonstrations and pilots outside of what happens directly in the practice setting.
- CMS appears to wish to address this to some degree in its upcoming Advanced Primary Care (APC) demonstration by requiring integration and alignment with community resources and public health programs.

Engaging Patients



Engaging Patients

- Approach #1: Focus solely on practice transformation
- Examples: Many!
- Focus on practice mastery of self-management education and support, care coordination and care management, and development of related skills, such as motivational interviewing
- Provide educational materials within the office
- Strengths: These efforts are necessary for medical home effectiveness
- Weaknesses: The efforts will not always be enough to activate the patient and support behavior change

Engaging Patients

- Approach #2: Use community-based teams to provide supplemental services and to create linkages to non-medical support services
- Example: Vermont
- Nurse coordinators, social workers, dietitians, community health workers, and others form Community Health Teams. Living in the communities they serve, CHTs offer patients counseling, self-management coaching, linkages to non-medical resources (e.g., food stamps), and links to other services. CHTs also work closely with hospital discharge planners and public health specialists. Each CHT is shared among practices and funded jointly by public and private payers.
- Strengths: Creates connections outside of the primary care office in support of good health; potentially a good model in rural areas
- Weaknesses: Significant resource investment and unclear how to construct in more urban environments

Engaging Patients

- Approach #3: Create practice linkages to public health programs to support consumer engagement in behavior change
- Example: Maine
- Practices must be connected to the state's local Healthy Maine Partnership (HMP). HMPs offer residents tobacco cessation services, anti-obesity coaching, asthma support, and a variety of other services intended to promote health statewide.
- Strengths: Leverages existing resources, expands scope of consumer engagement
- Weakness: States' public health resources are typically constrained – especially now

Soliciting and Selecting Practices

- Medical Home initiatives differ in terms of their target. Key design considerations can include:
 - Patient population (e.g., Medicaid beneficiaries, children, Children with Special Health Needs, adults with diabetes, etc.)
 - Practice capability (e.g., small practices with limited resources, larger practices with significant pre-existing infrastructure and capability, etc.)
 - Representativeness – for practices and payers
 - Geographic focus (if any)
 - Payer financial implications of practice selection

Soliciting and Selecting Practices

- State-based solicitations vary in format and length
 - Brief paper or on-line application of only a few pages
 - Lengthy state Medicaid request for proposals (RFP) document
- State Medicaid legal counsel will seek more structured processes when the process is designed to be a competitive procurement
- Long RFPs are likely going to prove an impediment to practice applications – especially from small practices
 - Can seek tech. assistance from the local chapters of the AAFP, ACP, AAP and AOA.

Soliciting and Selecting Practices

- DHHS may not be able to discuss solicitation content with the Council, but some content might include...
 - Practice requirements, and planned state financial and technical support
 - Request for basic practice descriptive information
 - Assessment of practice infrastructure and basic capabilities (fully staffed, broadband access)
- Traditional state selection processes using predefined selection criteria
- If the state partners with BCBSNE, the insurer may want to be able to advise the selection process

Evaluating Impact

- The evaluator should be identified at the outset
- Commonwealth Fund evaluators completing a common framework for medical home evaluations – may want to align with that one. Common areas of measurement include:
 - Patient experience
 - Physician and practice experience
 - Utilization and cost
 - Quality as defined using process and outcome measures for
 - Preventive care
 - Chronic illness care

Evaluating Impact

- Evaluation design can not be completed until the intervention has been completed, but it is worth having the evaluator be party to design conversations
- Rigorous designs include a pre/post analysis with a control group
- The smaller the pilot, the more difficult it is to detect statistically meaningful differences, especially as moving beyond the most gross measures
- Modeling for Texas Medicaid pediatric pilot indicated a minimum of 5000 Medicaid patients needed to detect significant differences in EPSDT visits

Summary

- Focusing on the core design elements will facilitate the planning process.
- The significant number of other medical home initiatives allows for borrowing of the ideas which appear most worthy.
- Success is not assured, so careful consideration of key design decisions can be critical.
- Implementation will every bit as important as design.

Responses to Advisory Council Questions

- Is there a type or size of practice that is more successful? (Dr. Wergin)
 - Small practices have to undergo greater change, but they also tend to be more nimble than large practices.
- What type of sample size is needed to measure success? (Dr. Knowles)
 - Probably 5000-10000 at the least, but power analysis with the evaluation measures of interest is necessary to assess.
- How you do define/set achievable goals for the practice sizes that will be participating in the pilot? (Dr. Knowles)
 - The goals need to be improvement on the goals to be set for quality (including access), patient & provider experience and cost.

Responses to Advisory Council Questions

- What makes a medical home pilot financially attractive to the practice and what thresholds should be set? (Dr. Hickey)
 - Some practices will participate simply if technical assistance is provided gratis. Others require supplemental payments. More on payment amounts later in the afternoon.
- If a guarantee is made in terms of compensation, how could it be funded through a public entity? (Dr. Hickey)
 - States fund supplemental payments – they just need to have the funds in their budget somewhere.
- 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)
 - There are ample examples of successful partnerships. The barriers are not profound so long as the payers have common interests.

Responses to Advisory Council Questions

- Is it beneficial to define practices by the use of a specific EMR instead of geographical locations? (Dr. Werner)
 - No. There are too many EMRs in use to limit practices to one.
- What are the characteristics of a practice that will be successful? (Dr. Werner)
 - Leadership, commitment to change, patient registry and broadband access.
- 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)
 - The APC pilot will probably be announced in Q1 2010. The seek multi-payer pilots that will be operational in 2010. CMS has communicated limited information, but Pat can obtain from NASHP.

Responses to Advisory Council Questions

- 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)
 - You should be able to demonstrate improved processes and outcomes for targeted chronic conditions, reduced cost for high-risk patients, and improved practice experience.
- 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)
 - CAHPS CG and PACIC are two tools in use, but neither is a tool for assessment of function and well-being like the SF12 or SF36.