

Health Quality and Cost Council
Patient Centered Medical Home Workgroup
Medical Home Foundations Subgroup
Meeting Summary
April 24, 2009
9:00-10:30 a.m. EST
Via Teleconference

Purpose

This group will balance the ‘state of the art’ in medical home development with Maryland-specific needs and will consider how a state-wide plan can complement the several single payer demonstrations that are in the planning stages, or are now underway, in Maryland.

Discussion Summary

The meeting began with a discussion of the Patient-Centered Primary Care Collaborative’s definition of the medical home: “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.” Consensus of the participants was that the definition should include the fundamental concept that comprehensive primary care includes all patients and places emphasis on the role of the patient’s family and community, in addition to placing an emphasis on the collaborative approach to the provision of care which is culturally and linguistically appropriate. Dr. White suggested that a new draft definition would be disseminated for discussion at the next meeting of the Subgroup.

The Workgroup then turned to consideration of designating recognition methods, such as the National Committee for Quality Assurance’s Physician Recognition tool for the patient centered medical home. The NCQA tool would be appropriate for recognizing pediatric and internal medicine practices.

There was discussion regarding the primary care specialty societies’ statement of joint principles for a medical home. With regard to principles 1 and 2:

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.

The American Academy Family Practice (AAFP) position is that team leaders should be physicians, rather than clinicians, some demonstration projects have included nurse practitioners as team leaders. Several work group members recommended allowing nurse practitioners to serve as team leaders in light of the current primary care physician shortage.

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.

Workgroup participants agreed that the use of registries to connect all patients to a medical home is implicit within the joint principles. Maryland’s principles should emphasize the whole person orientation, providing for all of the patient’s health care needs throughout all stages of the patient’s life. In addition, an assurance that all patients have a medical home should be included. This principle assumes that an individual has a physician. There should be an explicit goal to encompass population-wide enhanced access to care. Due to

the fact that the provision of mental health care services by primary care physicians often goes unrecognized, discussion focused upon the need to emphasize that behavioral health care is explicitly included.

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.

It was suggested that with the passage of the American Recovery and Reinvestment Act (“ARRA”) funds for electronic health records (EHRs), and legislation recently passed at the state level, we now have a mechanism for public and private payer participation. (HB 706—Electronic Health Records, Regulation and Reimbursement. The bill can be viewed at: <http://mlis.state.md.us/2009rs/billfile/HB0706.htm>.) Many participants noted that electronic health records systems are necessary for a practice to **function** as a PCMH, although the NCQA does not require it for PPC-PCMH Level I recognition. Often physician practices are not using the registry function even when available within an EMR. This relatively basic tool, a simple example of which is shown below, is critical for patient population management.

Diabetes Tracking Worksheet															
NOTE: DO NOT COPY AND PASTE DATA FROM CELL TO CELL AS THIS MAY UNDO IMPORTANT FORMATTING.															
KEY: A1c = hemoglobin A1c; DFE = dilated fundoscopic exam; BMP = basic metabolic panel; BP = blood pressure															
Patient name	Sex	Date of birth	ID number	Provider	A1c	Date of last A1c	Date of last DFE	Date of last foot exam	Date of last BMP	LDL	Date of last lipids test	Systolic BP	Diastolic BP	Date of last BP	Co-morbidities
Adams, Jane	F	03/14/56	111-11-1111	Ortiz	6.5	1-Mar-06	1-Apr-05	1-Mar-06	1-Mar-06	75	23-Nov-05	140	90	23-Nov-05	HTN, obesity
Baker, John	M	10/05/70	222-22-2222	Ortiz	5.7	24-Feb-06	12-Dec-05	24-Feb-06	24-Feb-06	90	24-Feb-06	110	75	12-Dec-05	
Brown, Jane	F	02/22/63	333-33-3333	Ortiz	6.3	23-Jan-06	24-Jul-05	23-Jan-06	23-Jan-06	103	23-Jan-06	105	85	23-Jan-06	HTN, Retinopathy, DJD
Carter, John	M	07/05/73	444-44-4444	Ortiz	7.8	16-Feb-06	20-Mar-05	16-Feb-06	12-Nov-05	98	12-Nov-05	131	75	16-Feb-06	
Doe, Jane	F	08/06/66	555-55-5555	Ortiz	6.8	24-Oct-05	21-Jul-05	24-Oct-05	24-Oct-05	88	24-Oct-05	120	80	24-Oct-05	
Douglas, John	M	07/01/49	666-66-6666	Ortiz	7.5	8-Aug-05	2-Feb-05	9-Jan-06	9-Jan-06	87	9-Jan-06	130	80	9-Jan-06	HTN
Jones, Jane	F	10/01/42	777-77-7777	Ortiz	6.2	19-Dec-05	16-May-05	19-Dec-05	19-Dec-05	99	19-Dec-05	128	77	19-Dec-05	
Lane, John	M	01/01/64	888-88-8888	Ortiz	6.4	31-Jan-06	31-Jan-06	31-Jan-06	31-Jan-06	67	31-Jan-06	115	80	31-Jan-06	
Smith, Jane	F	07/31/38	999-99-9999	Ortiz	6	17-Dec-05	17-Dec-05	17-Dec-05	17-Dec-05	100	17-Dec-05	130	80	17-Dec-05	
White, John	M	02/28/53	000-00-0000	Ortiz	7	29-Dec-05	18-May-05	29-Dec-05	29-Dec-05	76	29-Dec-05	120	75	29-Dec-05	

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.

Workgroup members were satisfied with principle number 5.

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.

Consensus among the Workgroup members was to support this principle. It was seen as a tool for reducing the number of patients who seek care from emergency departments. In addition to the issue of patients’ 24 hours/seven days a week access, this principle assumes that electronic and other non face-to-face communications between clinicians and patients will be reimbursed as part of an expanded fee schedule or as part of the capitated PMPM capitation payment. If these services were not reimbursed in some form, the clinicians in the work group contended that the services could not be offered.

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.

Ben Steffen observed that measures agreed upon in a bill passed during the 2009 Maryland legislative session provide that systems must meet a set of standards set by a national consortium. (HB 585/ SB 661) This bill establishes requirements for the Maryland Health Care Commission (MHCC) to approve “ratings examiners” to review “physician rating systems.” The bill prohibits carriers from using a physician rating system unless the system is approved by a ratings examiner. To use a physician rating system, carriers must establish an appeals process for physicians and disclose specified information to physicians at least 45 days in advance of making evaluations available to enrollees or altering a physician rating system. The bill can be viewed at: <http://mlis.state.md.us/2009rs/bills/hb/hb0585e.pdf>

Mr. Steffen summarized the potential enhancements to the Joint Principles of a Patient Centered Medical Home that had been outlined in the memo previously circulated to the workgroup (available: http://dhmh.state.md.us/mhqcc/materials/pcmh/PCMH_Subgroups_Memo.pdf) Mr. Steffen noted that:

- Enhancement Option 1 had been covered;
- Enhancement Option 2: close integration with the specialties is implicit within the concept of a medical neighborhood;
- Enhancement Option 3: NCQA emphasizes more patient-centeredness. This is not broadly defined and the patient has a leadership role; and
- Enhancement Option 4: the non-physician medical team leadership concept requires follow-up to delineate those services that nurse practitioners and physician’s assistants can provide in Maryland. All nurse practitioners and physician’s assistants must have a relationship of some sort with a physician. Most nurse practitioners provide specialty care, not primary care, medical services. The participants affirmed the importance of linkage from the PCMH to specialty care and other sites of care, including hospitals, nursing homes, and community based services. There was a general agreement that information technology played a critical role. Without enhanced information technology, linkage would be very difficult.
- Enhancement Option 5: Importance of including safety net providers. FQHCs play an important role as a safety net and provide care to a broad section of the overall population. Due to the fact that the representatives from the FQHCs were no longer on the call, this concept was tabled until the next meeting.
- Enhancement Option 6: Professional education and change management. No changes were necessary.
- Enhancement Option 7: Primacy of Chronic Care Model. Further discussion focused on the need for case management for all patients. Payers may determine that payment of a case management fee for all patients would be cost prohibitive. Some PCMH demonstration projects, such as Pennsylvania’s, focus on patients with diabetes and asthma.

Ben Steffen noted that a draft definition and the principles regarding additional outreach to pediatric practices and consideration of the recognition issues would be discussed at the next meeting of the subgroup, in addition to Enhancement Options 4, 5 and 7. Two additional meetings will be scheduled for this subgroup in the near future.

Teleconference Participants

Council members: Kathi White, Chair

Other participants: Kathie Baldwin (Mid-Atlantic Association of Community Health Centers), Robb Cohen (XLHealth), Richard Fornadel (Aetna), Virginia Keane (University of Maryland), Tracy King (Johns Hopkins School of Medicine), Judy Lee Nguyen (Merck), Sarah Reese-Carter (MD/MA Health Kids Program) Carol Reynolds (Potomac Physicians), Jon Shematek (CareFirst BCBS), Pegeen Townsend (Maryland Hospital Association), Jay Wolvosky (Baltimore Medical System)

Staff: Nicole Stallings, Ben Steffen, Orion Courtin, Rebecca Perry, Karen Rezabek