

**Health Quality and Cost Council**  
**Patient Centered Medical Home Workgroup**  
**Practice Transformation Subgroup**  
**Meeting Summary**  
**April 27, 2009**  
**3:30-5:00 p.m. EST**  
**Via Teleconference**

**Purpose**

This group will examine the technical, administrative, financial, and legal issues that would arise if a multi-payor demonstration is established in the State.

**Discussion Summary**

The meeting began with an overview of physician practices in Maryland presented by Ben Steffen, which can be viewed at:

[http://dhmh.state.md.us/mhqcc/materials/pcmh/Practice\\_Transformation\\_subgroup\\_042709.pdf](http://dhmh.state.md.us/mhqcc/materials/pcmh/Practice_Transformation_subgroup_042709.pdf)

The presentation focused on physician supply for primary and specialty care in Maryland, as well as annualized growth in use of practitioner services per patient, annual compensation, for selected specialties, provider shortages, and federal and Maryland efforts to enhance physician practice operations.

Kathy Francis, Chief of Health Information Exchange, Maryland Health Care Commission, provided an update regarding Maryland's participation in Phase I of the Centers for Medicare and Medicaid Services' Electronic Health Records demonstration project. Ms. Francis said that of 1,900 Maryland physicians participating in the project, 1,377 are members of physician practices with less than ten physicians and 4 are members of physician practices with less than twenty physicians. These physicians' practices represent all geographic areas of the state of Maryland, with five located in southern Maryland, ten from the Maryland's eastern shore region, eleven located in western Maryland, 96 from the central Maryland area, and five practices located in the District of Columbia.

The Workgroup then heard a presentation by Barbara Johnson and Sheila Richmeier, Senior Analysts for TransforMED, which is providing consulting services to CareFirst BlueCross BlueShield and the Johns Hopkins Bloomberg School of Public Health Guided Care model. Ms. Johnson and Ms. Richmeier discussed challenges in transforming medical practices from physician-centered to patient-centered care. They emphasized that many physicians believe that they can simply add on to their existing structure to become a medical home. TransforMED staff's point of view is that permanent change from a physician-centered practice to a patient-centered team approach requires a paradigm shift in the practice's management perspective. They view having a committed team leader and a collaborative relationship with other physician practices as keys to practice transformation that can be sustained.

With respect to the steps that practices must take, TransforMED recommends a quantitative and qualitative assessment of the practice's processes, a site visit, including interviews with key members of the practice's staff, completion of the MHIQ survey, and a change readiness assessment. Their goal is 80-20 leverage, where 20 percent of the practice's effort results in an 80% reward. TransforMED typically recommends that practices identify their strengths first and then address their weaknesses. Examples of this process included:

- Identifying physician leadership as a strength, but then discovering that the physician is working 12-14 hour days. The practice then needs to address the ways in which the team is/is not being used.
- Identifying that the practice has system integration as an established goal is a strength, but then identifying that the practice isn't really using it very well. The practice should address messaging and communication between the front and back desk.

TransforMED's national demonstration project included 18 self-directed practices and 18 facilitated practices. In response to a request for data regarding the costs of support and how that can be figured into any type of project design, Ms. Johnson replied that Transformed will be releasing results from their evaluation team in June. In working with practices, TransforMED has devised a change readiness assessment for the most cost effective and sustainable models and depending on the assessment, could do a combination of virtual or on-site consultations. In addition, they offer a low-cost medical home network service which includes templates, webinars, a list serve, and opportunities for collaboration nationwide.

With respect to a question regarding the American Academy of Family Physicians' Road to Recognition tool, Ms. Richmeier replied that the Road to Recognition tool is a good first step for understanding the elements of a patient centered medical home. Ms. Johnson added that recognition with NCQA is sometimes required in TransforMED's pilot projects, so they help the practice get ready for NCQA recognition. Achieving NCQA PPC-PCMH recognition can be an expensive endeavor. TransforMED noted that there are many free resources from the AAFP, the American Academy of Physicians (ACP) and the American Academy of Pediatrics (AAP). AAFP's Road to Recognition tool is helpful for guiding practices in formalizing and documenting the processes that they have in place. The NCQA's tools, as well as the Road to Recognition tool, are intended to provide practices with a roadmap for establishing a PCHM. The tools are necessary as practices go through the recognition process, as well as later doing the transformation of the practice to a PCMH.

Discussion then centered on the subsidization of the cost of recognition. It was noted that the vehicles for subsidizing recognition are independent from the vehicles for sustaining transformation and that a capitated PMPM for care management, a reward payment, and standard FFS are critical for sustaining a PCMH. One participant mentioned that plans and other organizing bodies have subsidized recognition costs in some of the demonstration projects around the country.

CareFirst reported that they are supporting the transformation consultants and are funding outcomes rewards when clinical measures are met. The CareFirst demonstration project requires practices to have a patient centered medical home Level II designation at the end of the first year in order for the practices to continue in the demonstration project. CareFirst also incents physicians, through CareFirst Quality Rewards in its Pay for Quality program, if they are able to achieve patient centered medical home designations, as well as the individual condition-specific NCQA program.

Dr. White then turned to the final agenda item, challenges for payers. CareFirst noted that it is at the beginning of a two year demonstration project. Participating practices are identifying where the opportunities lie for them, through the assessment tools, so that jointly they can develop a project and move toward a patient-centered, not a physician-centered, model of care. The CareFirst project has eleven participating practices, representing 89 physicians and 13 nurse practitioners. Several themes surfaced at the recent collaborative meeting—discussions about the licensure required to perform various functions in treating patients and finding better, or smarter, ways to meet patients' needs. The issue of compensation is a persistent theme. Each of the participating practices is receiving individualized support, including participating in the demonstration list serve, Level 2 NCQA PPC-PCMH designation assistance, standardized milestones, and individualized results. The MHIQ assessment tool and additional resources are available at TransforMED.com at no charge.

When asked whether a leader or a transformation agent is necessary as a first element to a demonstration, Dr. Merrill's opinion was that practices must have a change agent and a coach to be the touch point, due to constraints on time and energy. Dr. Reynolds noted that her practice has NCQA recognition as a medical home, which they did on their own; however, some physicians having had corporate relationships in the past was one key, due to the corporate nature of the NCQA process. She added that electronic tools make it all so much easier to assess the practice. Depending upon the practice and what is actually involved in the practice, something more than pen and paper or a basic practice management system is needed. Electronic tools make it all move along much faster.

Ben Steffen observed that outreach will be to be more difficult for a multi-stakeholder demonstration, and while the recognition tools should be used, the broader challenge of maintaining and sustaining the transformation itself will be challenging. He suggested that if members would like to further elaborate and build on these ideas and any other thoughts, they should email Karen Rezabek: [krezabek@mhcc.state.md.us](mailto:krezabek@mhcc.state.md.us). He requested that anyone willing to assist the Workgroup by chairing the Transformation Subgroup or the Purchasers and Consumer Information Subgroup to contact Dr. White or himself by email.

### **Teleconference Participants**

*Council members:* Kathi White, Chair, Roger Merrill

*Other participants:* Salliann Alborn (Maryland Community Health System), Tricia Barrett (NCQA), Colleen Devaul (Merck), Anne Doyle (CareFirst), Kathy Francis (MHCC), Barbara Johnson (TransforMED), Judy Lee Nguyen (Merck), Liz Pettengill (Greater Baltimore Committee), Carol Reynolds (Potomac Physicians), Sheila Richmeier (TransforMED), Eric Sullivan (United Healthcare), Brenda Wilson (Maryland Insurance Administration), and Grace Zaczek (Maryland Community Health Resources Commission)

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