

Medical Home Definition/Certification Workgroup Workday Minutes

Wednesday, September 2, 2009 – Urbandale Public Library

Welcome/Introduction – Bery Engebretsen

- Introductions were given. We pulled the workday together to have discussions on certifying medical homes in Iowa.

Overview of Key Documents/Resources – Bery Engebretsen

- The Commonwealth Report, *Building Medical Homes in State Medicaid and CHIP Programs*. Half used their own definition and half used the Joint Principles definition. This workgroup agreed on the definition laid out in HF 2539, which uses the Joint Principles as a template.
- *Evaluating the Tools Used to Assess the Medical Home* doesn't recommend NCQA because it doesn't evaluate all components of a medical home and hasn't been studied in terms of reliability. Their choice is one that they developed at their institution, the Primary Care Assessment Tool (PCAT).
- The PCAT assesses what the patient thinks the organization is doing in terms of medical home.
- TransforMed has a tool that is free and includes a crosswalk tool to NCQA.
- A challenge is that a lot of the tools rely on self-reporting and there's not a lot of external evaluation.
- Medical homes will provide better quality and lower cost. With us certifying, should we certify something that organizations are already doing or certify for what they want to become? Anytime you measure, you will measure a point in time. This is a long journey and not something that you change a few things to achieve it.

Accountable Care- Nat Kongtahworn

- One of the challenges is care coordination. What does that look like? North Dakota has an integrated delivery system; the care is already coordinated. There's an article in the *Annals of Internal Medicine* (Feb 09) that suggests the creation of peer webs, which are paid for care across the continuum for particular beneficiaries. From a Wellmark perspective, a peer web might be level 1.

- North Dakota has 5 delivery systems that deliver to 90 percent of their population. They aren't experiencing any challenges with care coordination. Iowa needs to take a broader perspective at how do we involve the community.

Workgroup Discussion- Certifying Medical Homes in Iowa

- Don Klitgaard said that this will be at least a 5 – 7 year progress. There are still practices that haven't even begun thinking about this. Nationally NCQA is the main certification used, but it is limited. They use too much health information technology and they don't measure patient experience etc. The NCQA tool will continue to develop, they are aware of the limitations. All of the national discussions will have quality discussions, about changing from quantity of care to quality.
- Improving outcomes takes a lot of change in process. Whenever certification is mentioned, that's what it's going to take to get some practices motivated. Are we going to come up with standards that Iowa wants to meet and measured on, or is this more a conceptual way of separating you from other practices? From the national discussion, in the next 3-6 months there will be some certification/rules for payment and measuring medical homeness. The Whitehouse isn't thrilled with NCQA.
- Bery - The challenge is that we would hate to have multiple assessment tools. CMS we won't have much influence over, but Medicaid and our local private insurers might be amenable to suggestions. Medical home certification should also be as aligned with the HIT "Meaningful Use" matrix as possible.
- Carrie Fitzgerald mentioned that HF 2539 lays out that the 1st group we are to cover is children in Medicaid. She is concerned that if we focus on everybody, that children will be left out and their issues are often different.
- Klitgaard- He demonstrated that when using the disease registry. He could pull out children and manage them differently than adults. These are a few things that changed in his practice to focus on kids:
 - Changed access issues. Moved to advanced access to get sick kids in faster.
 - Extended hours
 - Relooked at immunization process. They hired an immunization nurse who proactively checks immunizations.
 - Enhanced communication with public health department.
 - Used his registry to identify at risk kids.
- Medicaid doesn't have much money, and they are paying more for screenings, but not for surveillance. How much do we align certification with payment?
- Iowa was recently chosen as one of eight states for the National Academy for State Health Policy (NASHP) Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Participants. NASHP is supported through a

grant from The Commonwealth Fund, to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes. Each state will receive a one-year program of technical assistance to support their efforts. Things are aligning more now.

- Carlyle- we should consider using a certification method that will allow us to use it for pilot projects. From the reimbursement side, we need to look at kids and adults together. Hoping that there's money for health care reform for underserved adults. The money may be adult oriented because many kids are being covered under *hawk-i* or CHIP. Kids are for such a smaller population and practices won't be able to transform their entire practice for them.
- Transforming must be for all patients. Klitgaard has two health coaches that manage their disease registries. If kids have different needs, you can have a separate intervention set for kids. Once the technology and the process (registries/health coaches) are in place, providers will be able to manage patients in a very different way.
- Haas- Initially, our goal was to reduce cost and improve outcomes. Eighty percent of costs are for chronic diseases; therefore we need to modify lifestyles with proactive prevention. He suggests working toward a wellness model and allowing providers to be rewarded for preventing chronic conditions.
- Private practices and the local public health department need to work closer together. Public health has experience with population health management.
- Childhood obesity, for example, needs to be at the community level. Reimbursing for lowering BMI may be outside of practices control, but could be approached at a community level.
- NCQA has broad criteria. We need to bring practices into the mindset that they need to be looking at that. The specific goal of lowering BMI is down the road quite a bit.
- Nat- Do you pay for being a medical home or do you pay for being on the path to becoming one? Wellmark has a pay for performance program with 3 levels of performance. You have to create a cash flow associated with the path of getting to level 3, over time. They have their process measure for diabetes improvement. Level 1 is weighted to collecting the data, and has less emphasis on management. As higher levels, outcomes are the more significant measurement (such as lowering A1c).
- Klitgaard- this was a potential source of income for them, and a way to fund things that would better the patient's care and in the end have a positive impact in health. We should look at aligning Wellmark's program with a pilot project with Medicaid. They were able to pay for health coaches and organize themselves differently. The money doesn't go back to the docs it is used for practice transformation.
- The difference between practices at level 1 and 3 is their mindset. Those in level 3 believe it and have results to show for it. There's a lot of peer pressure to advance

- Bery- wrap up
 - This is an evolution, nationally. This makes it hard to take a stand on where we should move. Medical home is also an evolution and pathway for a practice, and you evolve on many levels.
 - Whatever we end up with, we would like ONE payment/certification process. Aligning payment among payer systems, EHR “Meaningful Use”, and any final certification process will be critical.
 - We need to remember children; they need special attention that doesn’t always relate to adults.
 - Include public health relationships and approaches in primary care medical homes. Use a “Wellness model”.

There was some discussion of specific elements for certifying medical homes in Iowa

- 24/7 access- have a nurse screen the calls before an upper-level doctor takes them
- This means at the practice level, not individual provider level
- Access- people are going to have to combine to meet within standards (I’m not sure what is meant here??)
 - Need to justify to payers that the service is merit
- If emergency rooms were more tied to primary care practices, it would be more efficient
- NCQA has it so you can set to your own practice requirements

Continuity

- Is it coordination, or seeing the same doctor continually?

Patient and family centered

- PCAT tool- this is how you bring in the patients perspective
- Carrie- have a parent of a child on the QI/patient advisory committees
- We don’t want the cost of the practice so high that the potential reward for the reimbursement is negated by the increased cost of data collecting, care management, registry use, etc.
- There are times in peoples life where their “Medical Home” is at a different place such as during pregnancy, or complex cases such as a lymphoma.
- Some patients don’t want to be a part of a medical home model.
 - There are expectations for both the medical home and the patient

- Patients, who only want to come in for the medications, are not seeing 'VALUE' in the visit.
- Part of being a medical home is getting to know your patient well enough that you know when someone's life is chaotic. You can work with this patient and connect them with community resources etc.

Next Steps

- We are going to further work on the chart Bery created. We will work with NASHP for technical assistance on a work plan. They will assist us in getting the proper route to certification determined.
- Practices in Iowa have already moved forward with NCQA. We need to consider them and somehow link with NCQA so they don't have to start over.
- The September 18th meeting in Iowa City may give us insights and thoughts about how things are going to go from here.

REMINDER: Next Council Meeting- September 18th Medical Home Symposium (Coralville)