

## MHSAC Leadership Team Workday Notes – 11-24-09

Attendees: Tom Evans, Beth Jones, David Carlyle, Abby McGill, Jennifer Harbison

### CHIPRA Quality Demonstration Grant- Children's Health Insurance Program Reauthorization Act

[http://www.cms.hhs.gov/CHIPRA/Downloads/CHIPRA\\_Quality\\_Demo.pdf](http://www.cms.hhs.gov/CHIPRA/Downloads/CHIPRA_Quality_Demo.pdf)

- The CHIPRA grant is dealing with infrastructure building, and has nothing to do with reimbursement. Their main focus is on quality measures.
- There are 5 different categories you can apply for: (\$5 million awarded per category per year, MAX)
  - A. Experiment With, and Evaluate use of Newly Developed and Evidence-Based Measures of the Quality of Children's Healthcare
  - B. Promote The Use of Health Information Technology (HIT) in Children's Healthcare Delivery
  - C. Evaluate Provider-Based Models Which Improve the Delivery of Children's Healthcare
  - D. Demonstrate the Impact of the Model Pediatric Electronic Health Record Format
  - E. Create a State or Multi-State Model Targeting an Issue Related to Healthcare Delivery, Coordination, Quality, or Access
- Iowa is applying for categories A-D. Iowa decided to apply by themselves. Some are doing a multi-state approach.
- Iowa is going to apply for **both** CHIPRA and CMS Multi-Payer Pilot. These are going to be aligned as parallel as possible.
  - o Have CHIPRA grant participants:
    - complete TransforMED baseline measurement
    - participate in the Medical Home Learning Community
    - We need to determine what the qualifying level would be. Use the same qualifying measures for both projects. Ex technology base-level.

### Iowa's Vision (15 minutes for Dec. 9 agenda) – Tom Evans Diagram (Socioecological Model)

- o Community-based care approach with metrics to measure effectiveness.
  - Measures- you aren't going to change what the provider does in a visit, you can change how the care is coordinated after they leave the office.
  - The community will manage the resources.
- o Timeline: we are at the beginning, building the infrastructure. We need to give the Council our vision. This isn't just a reimbursement, it is a different equipping practice and practices are going to have to develop a coordinating structure for primary care. We need to have a way of dealing with the outliers (dental etc)
- o There is a continuum. At the end is a vision of community-based care. The first step is the medical home and setting up practices within the community.
- o Pediatrics is already a public health focus. We are trying to get medical practices to join public health.

### Issue Briefs – high level visioning – Addresses reoccurring topics.

- Oral Health
- Pediatrics
- Patient- centered care
- Pharmacy
- Community Care Team (Utility Model)

**Legislative Health Care Coverage Commission** – Report Due January 1<sup>st</sup> (will list the accomplishments of the 3 workgroups). <http://www.legis.state.ia.us/asp/Committees/Committee.aspx?id=484>

- Workgroup 1- Coverage of Adults (David Carlyle- Chair)
  - o IowaCares is going to primary care shift. University of Iowa and Broadlawns still, tying in Community Health Centers.
  - o A diabetes registry for the uninsured.
    - Web-based (CareMeasures possibly)
    - Using Iowa Prescription Drug Corporation
    - Incentive is that you give them 90 days of drugs so you don't have to see them as frequently. Value is also that they are providing better care.
- Workgroup 2 – Use/Creation of a State Pool (Marcia Nichols- Chair)
- Workgroup 3 – Administration of Health Care Reform in Iowa (Ted Williams- Chair)

### **NASHP**

- 8 new states were there, and 4 mentor states. There were 12 states with 12 different models. Conclusion- they had a new understanding of the breadth of innovation.
  - o There isn't one way to do it.
  - o We need to figure out what the application will look like specific to Iowa's environment.
- Most states had one major insurer besides Medicaid. That's how Iowa looks. For the reimbursement piece, that's how most of the states were able to do their pilots.
- The NASHP workplan can become the workplan for the Council.
- We will provide NASHP's document that summarizes other states overall structure at the next Council meeting.

**Minnesota's Medical Home Definition** - <http://www.health.state.mn.us/divs/fh/mcshn/medhm/>

Medical Home is an approach to primary care where primary providers, families and patients work in partnership to improve quality and value in the health care system, and improve health outcomes for individuals with chronic health conditions and disabilities.

This approach improves the way the individual clinicians and the clinic systems work with and meet the needs of all individuals with chronic, complex health conditions or disabilities using the following tools and strategies:

- Developing trusting relationships with patients/families
- Partnering with and learning from patients and families
- Using a team approach for the care of chronic conditions, which includes planned, proactive visits
- Coordinating care
- Co-managing with patients/families and specialists
- Assisting with transitions
- Providing connections with community organizations
- Is satisfying for patients/families, providers and clinic staff
- Continuously works on quality improvement

# **DRAFT**

## **CMS Multi-Payer Advanced Primary Care- Anticipated Content of Application (slide 9)**

### **Problem Definition**

The patient-centered medical home (PCMH) is a quality-enhancing transformation of how primary care is delivered. Without a PCMH, a patient with acute or chronic illness is typically seen briefly in the office, a diagnosis made, and a prescription and/or lifestyle advice given. Getting the prescription filled, taking the medicine, changing behavior, and returning for follow-up if things aren't going better are left to the patient. Little attempt is made to provide care coordination or build productive partnerships with patients and other community service providers. This typical scenario represents an unacceptable quality of care and highlights a need for trained care coordinators, especially to follow the medically and socially complex patients once they leave the office.<sup>i</sup> Without a PCMH, even patients with insurance coverage might not have reasonable access to basic primary care services, and the care they do receive may likely be of lower quality and higher cost. Proponents argue that if the PCMH model is properly spread and supported, primary care, which currently receives about 7 percent of health care expenditures, can help reduce the remaining 93 percent of expenditures.<sup>ii</sup> Therefore, additional spending on the PCMH represents an investment that will pay dividends.

### **Description of program and how it addresses the problem**

The PCMH model integrates and coordinates care across the health care system and the community, ensures that care is patient and family-centered, and delivers care that is linguistically and culturally appropriate. Three trends are helping to build momentum around the PCMH model: 1) a growing shortage of primary care clinicians; 2) the increasing prevalence and cost of chronic diseases among the U.S. population; and 3) a growing recognition of the importance of evidence-based quality improvement in health care services.

PCMH spread and sustainability rely heavily on the continued development and support of the current primary care workforce; implementation of a health information technology system that connects all providers and collects appropriate data to analyze and demonstrate outcomes; a statewide prevention strategy that targets patients' behavior when not in the provider office; and a definable, coherent strategy that connects systems. When adults have a PCMH, their access to care and rates of preventive screenings improve substantially, and they report better management of chronic conditions.

### **Organizational structure and capabilities**

- Administrative/operational structure for multi-payer initiative
  - Iowa Healthcare Collaborative will be the lead agency and subcontract out specific tasks to others (Wellmark for reimbursement)
  - Iowa Department of Public Health and Iowa Nebraska Primary Care Association will be partners when needed.
  - The leadership team will vote on this (absent of Tom Evans). The group looked at all parties and discussed the barriers of creating a new entity, and decided that IHC is the best fit.
- Criteria for selecting and characteristics of participating practices
  - TransformMED.
    - Reason: We already have 36 practices that are used to using it as a scoring mechanism, and they have been using it for a year. TransformMED works with all types of primary care practices, and are also working with payors. The partners that brought together TransformMED are nationally discussing a certifying mechanism in conjunction with NCQA.

- The pilot would probably have 5 – 6 practices, who have gone through the MHLC and have a core TransformMED score.
- Iowa will have a validation process in place.
  - Audits would be done on that core score for validation.
  - Either TransformMED would do this, or we would need to figure out our own way.
  - We don't need to audit ALL of the practices, but we need to have a validation process and randomly select practices.
  - There is a spectrum of medical homeness within TransformMED. Whatever the practices' score is now, they will move up the line by a target score.
  - TransformMED will need to be tiered.
  - TransformMED is the starting place; a new revised NCQA a few years from now is the goal. Transformed is just for the purpose of this pilot.
- Methods of associating patients with practices
  - This assures that the patient and knows who their primary care provider is and what they can offer. (mutual understanding)
  - This could be a verbal conversation or a letter explaining it.
    - For a small amount of reimbursement, a letter is fine. A large amount of reimbursement,(CMS) a face-to-face conversation would be more appropriate.
- Methods of integrating community-based resources
  - If we have the same community for CHIPRA and CMS, they can be linked into the community care team, with the addition of adults.
  - From a Medicare oriented world, we need to think about meals on wheels, pharmacy, ePrescribing, home health, long term care, hospice, aging agency etc.
  - We will need to help them build an integration strategy in each community.
    - We could build a core model and they need to take that and employ locally. Their "team" would be in charge of doing this.
      - This is taking them from the 1<sup>st</sup> ring to the 2<sup>nd</sup> ring (tom's diagram)
      - This helps the practices build relationships with the resources

Iowa's community health centers, rural health clinics, and free clinics – along with maternal and child health clinics, family planning clinics, and local boards of health – collectively represent Iowa's safety net providers. Local boards of health are working to streamline public health services through implementation of Iowa's Public Health Standards. With the aid of funding from the state legislature, safety net providers strive to improve the coordination and quality of services for the uninsured. The Iowa Safety Net Collaborative Network was established in 2006. Initial planning focused on meeting the highest identified needs of access to pharmaceuticals and specialty care, along with recruitment of primary care providers.

The PCMH infrastructure under consideration must integrate all health services in a fashion that is both patient- and family-centered and easy to navigate. For example, Iowa is leading the nation in demonstrating the effectiveness of care coordination and collaboration through I-Smile, Iowa's dental home initiative. Through I-Smile, systems of health care providers ensure that children have access to early and regular oral health care. The I-Smile program links primary care and dental delivery systems through a patient- and family-centered approach. This same method can be implemented and expanded to provide a service delivery model and risk assessment protocol to meet various combinations of health care needs of patients in various settings.

- Integration with wellness/disease prevention efforts
  - A focus on metabolic syndrome which would identify people with pre diseases
- Intended use of and structure for housing multi-payer database
  - Similar to the Administrative/operating structure

### **Financial/payment arrangements (with supporting budget)**

- Payment of participating practices
- Payment for community-based care coordination services
- Payment for administrative services (including data support)

### **Evidence supporting projection of budget neutrality**

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<sup>i</sup> C.F. Wilson, Community Care of North Carolina: Saving State Money and Improving Patient Care, NC Med J, May/June 2005, Volume 66, Number 3.

<sup>ii</sup> A.H. Goroll et. Al., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, Journal of General Internal Medicine 22 no. 3 (2007).