



PATIENT CENTERED
MEDICAL HOMES

Maryland Multi-Payer PCMH Program

PCMH Advisory Panel

August 15, 2011

Agenda

- **Introduction and Review of the Role of the Advisory Panel**
- **Update on Program**
 - Program Status & Attribution/ Payments – Sue Myers
 - MLC – Dr. Niharika Khanna, Dr. Scott Feeser, and Ms. Sheila Richmeier
 - Quality Measurement reporting – Mr. Guy D’Andrea
 - Update on the Evaluation – Ms. Karen Rezabek
- **Program challenges discussion -- Dr. Khanna and Ms. Richmeier**
 - Care Management- including care coordination and care transitions
 - access to ER and hospital utilization data –
 - Mental health integration at various levels
- **Questions and public comment**
- **Wrap-up**

MMPP Metrics and Payment

Susan Myers

Manager Advanced Primary Care Programs

MHCC

Key Metrics

53 practices

339 practitioners

About 200,000 patients
attributed

- **Physicians**

- Family Medicine 133

- Internal Medicine 84

- Pediatric 59

- Geriatrics 1

- **Clinicians**

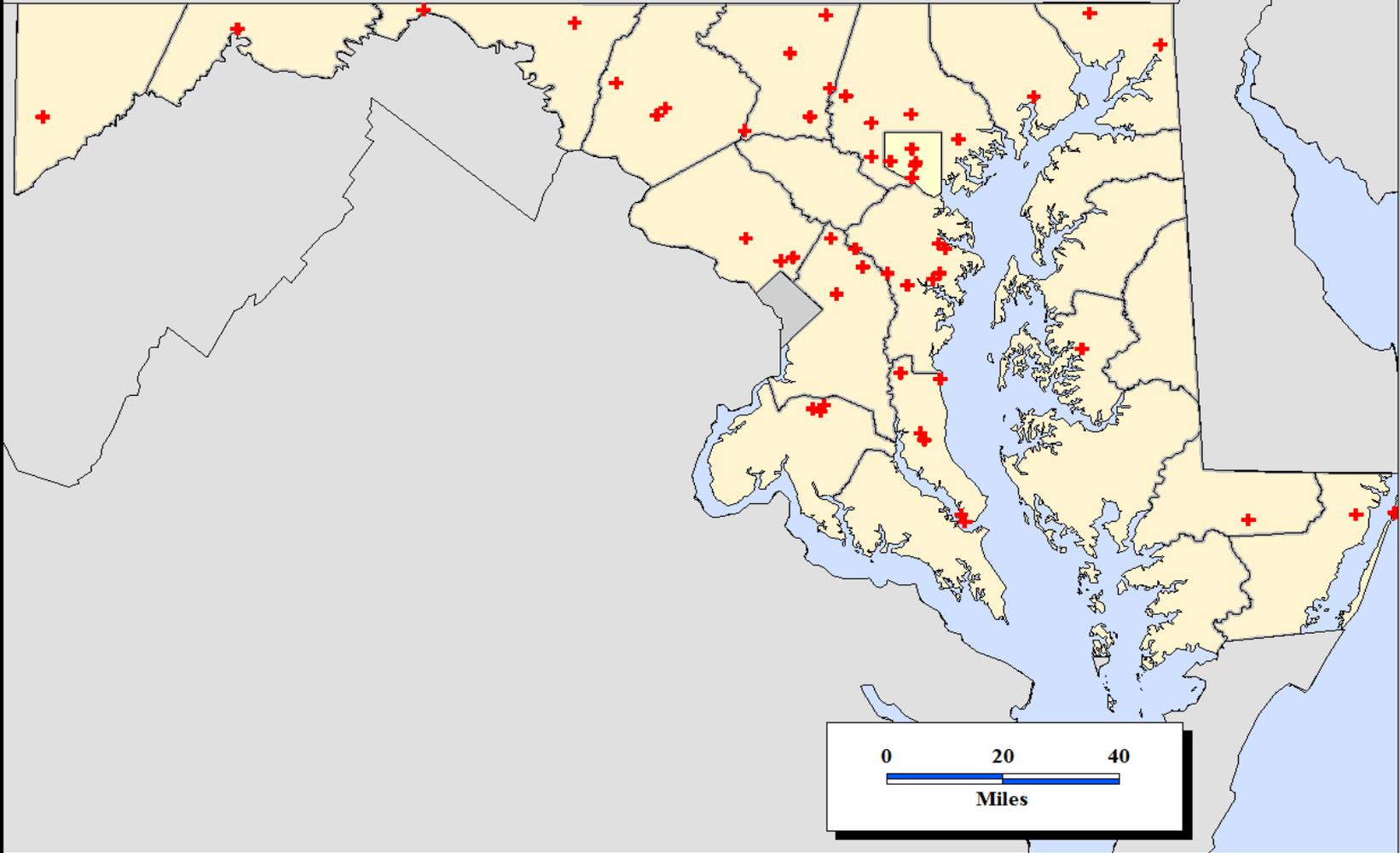
- Nurse Practitioners 39

- Physician Assistants 21

- Dentist 1

- Misc. 1

MMPP Practice Sites



Maryland Learning Collaborative

Niharika Khanna, MBBS,MD,DGO
Associate Professor Family and Community
Medicine



Maryland Learning Collaborative

will provide support for your transformation in the following ways:

Education

- Large Group Learning Collaborative Meetings
- Regional Learning Collaborative Meetings
- Curriculum Development for Practice Transformation

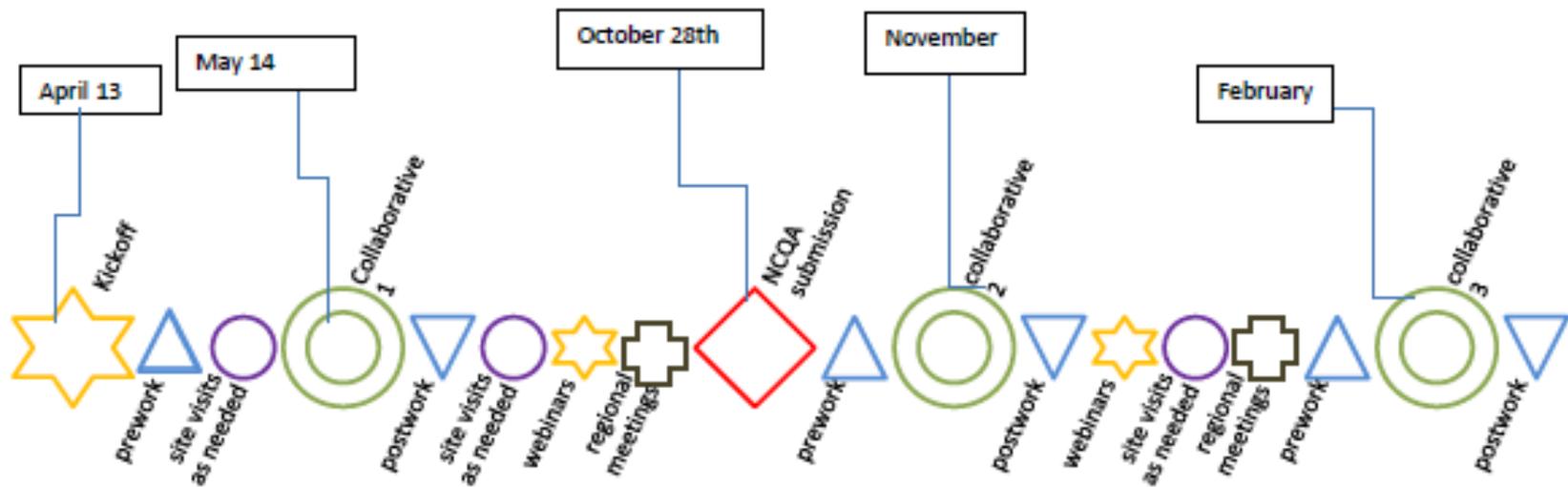
Advising

- Practice Self Evaluation and Planning Tool Development
- Webinars
- One on one advising

Consultation

- Group consultation
- Individual practice outreach- multi-media and direct contact
- Curricular innovations for learners

TIMELINE



prework



collaborative



regional meetings



postwork



NCQA submission



webinar



site visit

Practice Transformation three pillars: Teamwork Leadership Communication

- Practice Redesign Teams
 - Practice Champion- Physician or NP
 - Lead clinical and/or lead clerical staff member
 - Nursing supervisor
 - Lead Medical Assistant or Front office supervisor
 - Lead administrative person
 - Practice manager
 - Administrator or Office manager
 - Care Manager

Coaching vs. Facilitation

Coaching=Self help with expert guidance

Facilitation=being helped by expert

- Criteria for facilitation for 3-6 practices
 - Inability to perform planning
 - Inability to implement process
 - Resistance to coaching
 - Coach's feeling of issues
- Triggers for visits
 - Practices' participation is low
 - Having difficulty with phone support
 - Flags in communication
 - Practice ask for more support

Contact with 53 Practices

- Incoming phone calls
- Outgoing phone calls
- Incoming emails
- Webinars
- Outgoing letters to practice champions
- Site visits
- Large group Learning Collaborative
- Regional Learning Collaborative

Activity - Contacts

Since May 14th . . .

- 14 Incoming phone calls
- 16 Outgoing phone calls
- 81 Incoming e-mails
- 8 Outgoing reminder e-mails
- 6 site visits made
 - 6 more scheduled

Numbers reflect tracking





PATIENT CENTERED MEDICAL HOME Learning Collaborative



Funded by



Mr. Ben Steffen You are logged on.
[Logout](#)

[LEARNING COLLABORATIVE HOME](#)

[VIDEO](#)

[FACULTY](#)

[FORUM](#)

[MMPP PORTAL](#)

[MHCC PCMH](#)

UPCOMING COLLABORATIVE EVENTS

8/18/2011 (9:30 AM to 10:30 AM)

[Practice Manager Conference Call](#)

teleconference

Conference call for practice managers. Please use the following teleconference number: 1-512-225-3629. Guest access code: 963959#.

9/1/2011 (9:30 AM to 10:30 AM)

[Practice Manager Conference Call](#)

teleconference

Conference call for practice managers. Please use the following teleconference number: 1-512-225-3629. Guest access code: 963959#.

9/1/2011 (7:00 AM to 8:00 AM)

[Physician/Clinician Conference Call](#)

teleconference

Conference call for physicians and/or clinicians involved in the PCMH transformation. Please use the following teleconference number: 1-512-225-3629. Guest access code: 963959#.

MEETING DOCUMENTS

Care Manager Call Minutes

For 08/08/11, 9:30 a.m.

[Care_Manager_Call_Minutes_8_9_11_portal.docx](#)

EHR List by Practice

[EHR_List.pdf](#)

NEWSLETTER

Announcing "Maryland Learning Collaborative Connections"

Our new monthly newsletter!

[Newsletter_Announcement.docx](#)

May Newsletter

[May_Newsletter.pdf](#)



MARYLAND LEARNING COLLABORATIVE CONNECTIONS

CLINICIAN LEAD. STATE OF MARYLAND AND INSURANCE CARRIER SUPPORTED

Maryland Multi-Payer Project for Patient Centered Medical Homes

July 21st, 2011 Volume 1, Issue 2



Participating practices in the Maryland Multi-payer program for Patient Centered Medical Home

From the desk of Niharika Khanna:

The Maryland Learning Collaborative (MLC) is incredibly privileged to work with the hard working State of Maryland primary care practices. Being on the road to transformation with you is an extraordinary journey! We could never have

attribution and care management payments from insurances and the state to our practices. Most practices have identified or hired a care manager and have started to identify process for care management. (See Page 2)

The Maryland Learning Collaborative continues to provide education, advising and consulting for all our 53 primary care practices in practice transformation to NCQA (National Committee for Quality Assurance) recognized Patient Centered Medical Home (PCMH). At the regional learning collaborative meetings upcoming in August 2,3,4th we have invited NCQA representatives to present an interactive talk

In this issue:

Advancing Primary Care and Transforming Practices in Maryland 1

Practice Transformation Corner 1

Care Management 2

Contact 2

FIRST Finish Line

- Practice Transformation
- NCQA Level 1+ applications in by October 28th

- FROM OCTOBER 31st
- Practice Transformation continues
- NCQA Level 2+
- Practice Efficiency
- Care Management –Process development and measuring outcomes
- Mental health

Acknowledgements

- State of Maryland leadership for their vision
- MCHRC Mark Luckner
- Maryland Learning Collaborative Practice transformation coaches
 - Mary Bakel and Laura Benzel
- MLC Leadership Team-David Stewart, Kathy Montgomery, Norman Poulsen, Scott Feeser, Sheila Richmeier
- MHCC PCMH team- Ben Steffen, Karen Rezabek, Susan Myers
- NCQA – Mina Harkins
- Most of all – Insurance partners, Employer groups, stakeholders

- Patients, Practices
- Our advisors
- University of Maryland School of Medicine, Department of Family and Community Medicine

PCMH Recognition and Quality Measure Overview

Guy D'Andrea, MBA
President
Discern Consulting

Maryland NCQA Requirements

Requirements	Maryland + Level		
	1+	2+	3+
Level 1 NCQA Recognition	X		
Level 2 NCQA Recognition		X	
Level 3 NCQA Recognition			X
24-7 Phone response	X	X	X
Registry	X	X	X

Maryland NCQA Requirements, con'td

Requirements	Maryland + Level		
	1+	2+	3+
Same-day appointments	X	X	X
Summary for transitions	X	X	X
Care mgt. and coordination	X	X	X
Problem lists	X	X	X
Medication reconciliation	X	X	X

Maryland NCQA Requirements, con'td

Requirements	Maryland + Level		
	1+	2+	3+
Pre-visit planning, after-visit follow-up	X	X	X
Use of EHR		X	X
CPOE for all orders		X	X
E-Prescribing with decision support		X	X

NCQA Status

- Practices working toward NCQA submission by October 28, 2011
- MHCC developing protocol for assessing Maryland-required elements
 - Option 1: NCQA reports
 - Option 2: MHCC access physician reports from NCQA after practices authorize

PCMH Quality Measure Overview

- NCQA PCMH Recognition (including Maryland-required elements)
- 21 clinical process measures
 - 6 apply to pediatric practices
 - 18 apply to adult practices
- Outcomes/utilization measures
 - Reduction of hospitalizations
 - ER use
 - Readmissions

Measurement Timeline

- 2011
 - NCQA recognition (level 1)
- 2012
 - Report on clinical process measures
 - NCQA recognition (level 2)
- 2013
 - Report on clinical process measures
 - Apply thresholds for outcome/utilization measures
- 2014
 - Apply thresholds for clinical process measures
 - Apply thresholds for outcome/utilization measures

Clinical Process Measures

A = adult, P = pediatric

- A,P Asthma assessment
- A,P Appropriate medications for asthma
- A,P Asthma pharmacologic therapy
- P Appropriate testing for pharyngitis
- A Blood pressure measurement
- A Blood pressure control
- A,P Weight screening and follow-up
- A Tobacco assessment and cessation (2 measures)
- P Childhood immunizations
- A Influenza immunizations
- A Pneumonia vaccinations
- A Colorectal cancer screening
- A Diabetes: HbA1c <8%, HbA1c poor control, blood pressure management (3 measures)
- A Anti-depressant med mgt: acute phase and continuation phase
- A Ischemic Vascular Disease: lipid panel and LDL control
- A Heart Failure: ACE or ARB therapy
- A Coronary Artery Disease: oral antiplatelet therapy

Measure Status

Clinical Process Measures reported by practices

- First reports due February 2012 – submit aggregate data and attest
- MHCC developing:
 - Data submission tools
 - Measure specification resources for submission:
 - Via EHR/registry
 - From chart data

Outcome/Utilization derived from claims

- First assessed in year 2 of the program
- 30-day readmission rate
- Number of hospital days per 1,000 members
- Emergency room visits per 1,000 members

MMPP Program Evaluation

Karen Rezabek
Program Manager
MHCC

Update on the Evaluation

- An evaluation is required under the law.
- Evaluation Committee is in final review process
- Evaluation will be more costly than originally estimated
- Pre/post treatment with a quasi-experimental control group of similar practices
 - Control group will itself be undergoing some forms of change
- MHCC hopes to take recommendation to the Board of Public Works in September.

Program Challenges

CARE MANAGEMENT

Embedded Care Managers vs. Community-Based

- FUNCTIONS:
- Clinical Assessment including pre-visit planning and Care Plans
- Patient and Physician Goal setting and maintenance
- Care Coordination including care transitions
- Population management

Who should be Care Managed?

High Risk patients or High utilizers?

- Any patient with a chronic condition, including mental disease, who has/ or is likely to have 2 emergency room visits in 6 months and/or 2 admissions to a hospital in one year, OR any patient identified by PCP as high risk
- For practices with a high pediatric populations and low chronic disease: Care manager focus would be on preventing unnecessary emergency room use or hospitalization by outreach to identified patients, by patient engagement, education, outreach and linkage to community resources.

Evaluation of Care Management Domains

- Enhanced access to Primary care for high risk patients
 - Improved healthcare quality
 - Improved Quality of Life
 - ER visits and hospitalizations
 - Healthcare costs
-
- Personal Q: Does health care utilization cost identified high risk = physician identified high risk?

CARE MANAGEMENT OPERATIONALIZING

- Focus group on Sept 8th
- Large group with experts on Sept 21st
- Back to drawing board after that

Mental Health

Mental Health

Behavioral Health	Screening in High Risk patients for Depression, Anxiety+ PTSD,DV, Somatization	Managing Depression, Anxiety in Primary Care	SMI
Support Community linkages Care Manger education of at risk Population	PHQ-2 GAD-7 + PTSD,DV PHQ-15	Develop standards for care within Primary Care, Coordinate / communicate with Mental Health	Care Coordination Communication bet PCP and Psychiatry
Mental Health professionals educate PCP on “values” etc	Utilize Previsit summary which then converts to CARE PLAN Care Manager - Brief Intervention	Phone consultation with Psychiatrist? Vs integrated practices	Mental Health professionals educate PCP on “how to talk to SMI patients”

ADDICTIONS

Methods of Integration of Mental Health into Primary Care

- Four Quadrant Clinical Integration Model for Behavioral Health- 4 levels
- **NCCBH State Assessment of BH/PCP Integration Environment: 8-28-03**
- © 2003 by National Council for Community Behavioral Healthcare

A PHQ 3 or GAD 7 screen positive patient:

Should we train Care Managers to do Brief Intervention
OR Integrate Mental Health into Primary care?

Systematic
Communication
Method

Shared Medical
Records

Patient

Co-location of
PCP/Mental Health
Personnel

Shared Decision
Making

These ideas need to be fleshed out!

Questions?

Comments!

Wrap-up

Synergies and Externalities



"The Guided Care Nurse saved me time, and made my practice more efficient." *Guided Care Physician*

- HOME
- ABOUT US
- CONTACT US
- ADOPTION
- PUBLICATIONS
- IN THE NEWS
- OUR SUPPORTERS



[View our video](#) to learn more about Guided Care.

[Click here](#) to see additional Guided Care videos.

Care For

Guided Care conditions a 2-5 physician effective health assessment monthly, coordinated care, education

The Roger C. Public Health based primary 300 caregivers the quality of satisfaction expensive s

Guided Care **Excellence for Innovation** Physicians, Care was a The Guided **Platinum Award** Hopkins Health **Program** an



Protecting Health, Saving Lives – Millions at a Time

Acknowledgements

- State of Maryland leadership for their vision
- CHRC Mark Luckner
- Maryland Learning Collaborative Practice transformation coaches
 - Mary Bakel and Laura Benzel
- MLC Leadership Team- David Stewart, Kathy Montgomery, Norman Poulsen, Scott Feeser, Sheila Richmeier
- MHCC PCMH team- Karen Rezabek, Susan Myers, Linda Bartnyska, David Mitchell, Bridget Zombro, and Valerie Wooding
- NCQA – Mina Harkins, Tricia Barrett
- All carrier partners, employer groups, stakeholders
- Meeting supporters – Merck, Pfizer, and Sanofi-Aventis