



Ohio HB 198

Patient-Centered Medical Home Education Pilot Project

Final Work Product Report

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Rick Snow, D.O., Co-Vice Chair and Funding/Reimbursement Reform Taskforce Chair

Ken Bertka, M.D., Practice Selection/Metrics Taskforce Chair

Tony Costa, M.D., Curriculum Taskforce Chair

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PCMH Education Pilot Project Executive Summary

The Patient Centered Medical Home (PCMH) Education Advisory Group (EAG) and the Patient-centered Medical Home Education Pilot Program were created by Ohio's medical home statute (HB 198 of the 128th Ohio General Assembly). By statute, the EAG oversees implementation of the pilot program and seeks funding to support and sustain the initiative. The design of this pilot is unique because of its focus on education and advancing medical and nursing education in the PCMH model of care delivery.

Objectives of the pilot are:

- Facilitating more rapid adoption of PCMH model by primary care providers (PCPs)
- Creating practice sites where medical students, residents and nurses can experience PCMH model
- Revising medical student, resident and nursing curricula to incorporate PCMH principles.
- Attracting and retaining PCPs in Ohio by producing a more satisfying practice environment
- Enhancing quality of care delivered to citizens of Ohio
- Enhancing patients' health care experience in the primary care office and community
- Bending the health care cost curve making health care more affordable and accessible
- Creating an organization that would facilitate bringing available funding to Ohio for PCMH implementation.

While the objectives of the legislation were deemed vitally important as evidenced by the legislation's passage by overwhelming majorities in both the House and Senate, the legislation itself contained no funding. Nevertheless, EAG applied for and received a \$300,000 grant from the Ohio Health Care Coverage and Quality Council for the period December 1, 2010 through June 30, 2011 for the purpose of creating an organizational infrastructure, a sustainability plan and processes to launch and move the pilot project forward.

EAG chose to organize itself creating task forces by subject areas of funding/sustainability, practice selection/metrics, and curriculum design. Each task force approached its charge aggressively and produced substantial results.

The funding/sustainability work group, chaired by Richard Snow, D.O., worked with sustainability consultant William Hayes, Ph.D., on a sustainability plan. They also identified and explored potential funding sources for the pilot. The Sustainability Plan and Case for Support documents are included in the report under the tab titled, "Project Sustainability"

The practice selection/metrics work group chaired by Ken Bertka, M.D., worked in cooperation with TransforMED, to accomplish the following:

- Developed a practice selection process;
- Developed a pilot application form that would provide the necessary information about each practice to allow for a knowledge-based decision about each practices' suitability for the pilot;

- Established evaluation metrics upon which outcomes from the pilot practices would be measured;
- Recommended 44 practices as pilot participants to EAG for formal approval on June 15.

The full listing of the 44 selected practices (37 physician-led and 7 APN-led) and the practice metrics are provided in the section titled, “Taskforce Accomplishments – Practice Selection/Metrics Taskforce.”

While the work of the curriculum work group chaired by Tony Costa, M.D. was not an official charge nor specifically funded in the grant, failure to acknowledge their outstanding work in developing a patient-centered medical home curriculum for use in medical and nursing schools to train physicians and nurses how to deliver care in the PCMH model would be remiss. The developed curriculum has been included in the report in the section titled, “Taskforce Accomplishments – Curriculum.” and should be considered a bonus work product of substantial value to the future success of this project.

During the seven month grant period, EAG members, regional leaders, consultants and central administrator (Ohio Academy of Family Physicians), worked collaboratively to accomplish the following:

- Organized a statewide webinar and four regional town hall meetings to educate prospective practices as to pilot and the opportunity to participate
- Developed marketing materials to educate potential practice applicants as to the value of pilot participation
- Promoted pilot participation through available communication vehicles
- Developed practice selection criteria to ensure that suitable participants were selected
- Developed applications for pilot participation that would generate responses providing information necessary to select participants
- Completed a rigorous practice selection process - 65 practices applied for 44 slots. Regions provided local perspective/input and verified that applicants had/or were seeking the statutorily-required affiliated teaching agreements with a medical and/or nursing school. TransforMED evaluated practices for their patient-centered medical home transformation potential using established, evidence-based assessment tools. Statutorily-required board certification of selected practice physicians/APNs was verified by the State Medical Board and State Board of Nursing. The practice selection/metrics work group met twice to review and assess practices prior to making final recommendation for EAG’s formal approval on June 15
- Determined measurement metrics for pilot practices
- Developed sustainability plan and case for support; explored several promising funding opportunities that are pending
- Developed transparent and thorough PCMH Education Advisory Group Web site; regularly updated so volunteers, consultants and interested parties can follow progress.
- Developed curriculum for teaching medical students and nursing students how to deliver the patient-centered medical home model of care to patients (beyond the scope of grant charge and funding).

Addendums noted above and the attached materials arranged by tab (see table of contents) explain the scope and depth of the effort.

We are proud of the quality and value of work accomplished in such a short time frame (December 1, 2010 – June 30, 2011) particularly given the fact that grant dollars were not available for expenditure until mid-February and the first three months of work were completed as a leap of faith that dollars would be forthcoming. Thanks to members of the Patient-centered Medical Home Education Advisory Group for the countless hours they volunteered toward this effort. Additionally, thanks to the Ohio Health Care Coverage and Quality Council, Ohio Department of Insurance and Ohio Medical Colleges Government Resource Center for their support of this project.

Respectfully submitted,



G. Patrick Ecklar, M.D.
Current Chair



Ted Wymyslo, M.D.
Past Chair



Jeri A. Milstead
Co-Vice Chair



Richard Snow, D.O., M.P.H
Co-Vice Chair

EAG Approved Practice Selections

June 15, 2011

East Central Region

App#	Full Legal Name of Practice	Primary Contact for this application	APN or Physician led?	City	Rural?	Financial Class			
						Mcaid	Unins	Mcare	Comm/Other
11	Center for Family Medicine	Elliot Davidson, MD	Physician	Akron	No	30%	5%	25%	40%
22	COMMUNITY HEALTH CARE, INC.	RODNEY K. ISON, M.D.	Physician	Canal Fulton	No	2%	10%	35%	53%
37	Dunlap Family Physicians	Marilyn Mahoney	Physician	Orrville	No	9%	15%	16%	61%
44	Family Medicine Center of Akron	Kathi Pronio, RN	Physician	Akron	No	35%	5%	10%	50%
39	Family Practice Center, Inc.	Becky J. Durbin	Physician	Orrville	No	12%	31%	16%	41%
47	Green Primary Care	Kenneth J. Braman, DO	Physician	Uniontown	No	6%	2%	31%	61%
4	Little Flower Family Practice	Donna Johns	Physician	Canton	No	1%	2%	43%	54%
41	MATTHEW P. FINNERAN, MD	MATTHEW P. FINNERAN, MD	Physician	WADSWORTH	No	1%	10%	25%	67%
46	North Hill Family Practice	Brian Bachelder, MD	Physician	Akron	No	23%	30%	19%	28%
28	The Nursing Center for Community Health	Annette R. Mitzel, RN, MSN, CNS	APN	Akron	No	0%	100%	0%	0%
18	Trumbull Family Practice	Pedro A. Ballester, M.D.	Physician	Warren	No	5%	1%	55%	39%

Northwest Region

App#	Full Legal Name of Practice	Primary Contact for this application	APN or Physician led?	City	Rural?	Financial Class			
						Mcaid	Unins	Mcare	Comm/Other
19	Archbold Medical Group	Keith J. Lehman	Physician	Archbold	Yes	12%	2%	31%	54%
30	Erie County Health Department	Janet Mesenburg	APN	Sandusky	No	44%	43%	2%	11%
3	Henry County Family Physicians, Inc.	Jennifer Recker	Physician	Napoleon	Yes	11%	2%	18%	69%
42	James T. Bowlus MD Inc	James T Bowlus	Physician	Elida	No	5%	5%	50%	40%
59	John T. Hanna, MD, FAAFP	John T. Hanna, MD	Physician	Galion	Yes	11%	6%	41%	42%
38	Mercy Internal Medicine Associates	Johnathon Ross MD MPH	Physician	Toledo	No	45%	15%	35%	5%
55	NOMS- Fremont Family Practice	Jennifer Hohman, MD	Physician	Fremont	Yes	15%	6%	13%	66%
49	Rosemary Karen Reiter MD	Jo Hines	Physician	Defiance	Yes	33%	3%	6%	58%
24	St. Luke's Hospital Family Medicine Center	Shelah Bechtel, R.N., B.B.A.	Physician	Maumee	No	29%	8%	25%	38%
50	University Pediatrics	Joan R. Griffith, MD	Physician	Toledo	No	71%	4%	0%	25%
25	West Side Family Health Care	Sheryl Tumblin, CNP	APN	Lima	No	30%	5%	30%	35%

EAG Approved Practice Selections

June 15, 2011

Southeast Region						Financial Class			
App#	Full Legal Name of Practice	Primary Contact for this application	APN or Physician led?	City	Rural?	Mcaid	Unins	Mcare	Comm/Other
48	Adena Family and Internal Medicine -Waverly	Kris Greene	Physician	Waverly	Yes	25%	4%	22%	49%
10	Adena Oak Hill Family Practice	Alicia Kammler	APN	Oak Hill	Yes	21%	6%	13%	60%
20	Colonnade Medical Group	Greer Edwards,RN	Physician	Lancaster	No	5%	5%	32%	58%
31	Family Health Services of Erie County	Wilson Forney	Physician	Sandusky	No	45%	40%	11%	4%
13	Family Healthcare, Inc.	Dawn Murray, D.O.	Physician	The Plains	Yes	40%	25%	9%	26%
61	Lucasville Family Practice Center	Terry A. Johnson D.O.	Physician	Lucasville	Yes	40%	5%	40%	15%
5	Perry County Family Practice	Theresa L Ulrich	Physician	New Lexington	Yes	45%	3%	35%	17%
65	Providence Medical Group, Inc. - Suburban Family Practice	Joni Koren, D.O.	Physician	Huber Heights	No	13%	3%	13%	71%
7	The MetroHealth Old Brooklyn Senior Health & Wellness Center	James W. Campbell, MD, MS, AGSF	Physician	Cleveland	No	11%	12%	66%	11%
32	University Medical Associates, Inc.	Lenard G. Presutti, D.O., FAFAP	Physician	Athens	Yes	36%	2%	33%	29%
14	Victor Cassano Sr. Health Center	James Schoen, D.O.	Physician	Dayton	No	45%	30%	20%	5%

West Central Region						Financial Class			
App#	Full Legal Name of Practice	Primary Contact for this application	APN or Physician led?	City	Rural?	Mcaid	Unins	Mcare	Comm/Other
12	Colbert Family Health & Wellness	Marquetta D. Colbert	APN	Trotwood	No	59%	0%	9%	32%
57	Family Health Services of Darke County, Inc.	Carlos Menendez, MD	Physician	Greenville	Yes	18%	12%	21%	49%
67	Integrated Medical Group	Katherine A Clark, DO, FAFAP, FAIHQ	Physician	Beavercreek	No	20%	4%	30%	46%
33	Maple Leaf Family & Sports Medicine, LLC	Boyd Hoddiontt, MD/ Jill Miller, Manager	Physician	Bellefontaine	Yes	5%	6%	14%	75%
53	New Carlisle Family Practice	Ashok Devatha	Physician	New Carlisle	Yes	22%	64%	5%	9%
29	Piqua Family Practice	Gretchen Lorenz	Physician	Piqua	Yes	5%	5%	30%	60%
26	Rinehart Family Health, LLC	Candy Rinehart, CNP	APN	Springfield	No	24%	1%	25%	50%
1	Robert P. Gill MD	Robert P. Gill MD	Physician	Minster	Yes	2%	1%	30%	67%
35	Rocking Horse Children's Health	James Duffee, MD, MPH	Physician	Springfield	No	74%	1%	10%	25%
8	West Jefferson Internal Medicine	Eric Yoon	APN	West Jefferson	No	60%	10%	10%	20%
68	Wright State Physicians Family Medicine	Phil Whitecar	Physician	Beavercreek	No	22%	8%	19%	51%

EAG Approved Practice Selections

June 15, 2011

Practices NOT Selected					Financial Class				
App#	Full Legal Name of Practice	Primary Contact for this application	APN or Physician led?	City	Rural?	Mcaid	Unins	Mcare	Comm/Other
34	After Hours Family Medicine LLC	Dora Richardson, CNP	APN	Seville	Yes	30%	20%	20%	30%
64	Family medicine occupational health center Inc.	Elizabeth Ranasinghe MD	Physician	Shaker Heights	No	80%	2%	8%	10%
52	FCMH Medical and Surgical Associates	James Burton	Physician	Washington CH	Yes	14%	8%	32%	46%
51	Freeda Flynn, M.D.	Freeda Flynn	Physician	St. Clairsville	Yes	40%	10%	40%	10%
60	Good Samaritan Family Health Center	Teresa W. Zryd, MD	Physician	Dayton	No	45%	18%	19%	18%
27	Health Partners of Western Ohio	Janis Sunderhaus RN, MSN	Physician	Lima	No	40%	40%	10%	10%
56	HMHP St. Elizabeth Family Health Care	Dr. Dinah Fedyna , M.D.	Physician	Youngstown	No	50%	1%	25%	24%
58	Integrated Medicine Professional Corporation	Jason D. Frohnapfel	Physician	St. Clairsville	No	Unk	Unk	Unk	Unk
63	LaSalette Personal Primary Health Care	Dr. Margarita Lassaletta	Physician	Wadsworth	No	10%	7%	20%	63%
17	Madison Family Practice	Melissa Becker, MD	Physician	Mansfield	No	5%	8%	20%	67%
16	McIntosh Community Health Center	Lauren McIntosh	Physician	Uniontown	No	5%	5%	30%	60%
21	Medical Home Primary Care Center	Matthew Watson	Physician	Zanesville	Yes	20%	10%	20%	40%
23	Mercy Family Physicians Perrysburg	Catherine Carrigan, MD, MBA	Physician	Perrysburg	No	20%	10%	20%	60%
9	Midwest APN Consultants, LLC	Tracy Murray	APN	Springboro	No	35%	0%	60%	5%
62	Muskingum Valley Health Centers	Julie Vandebark	Physician	Zanesville	Yes	43%	25%	11%	18%
2	Ohio Family Practice Centers, Inc.	James Dom Dera, MD, FAAFP	Physician	Fairlawn	No	2%	2%	15%	81%
54	Roxanne M. Cech, M.D., LLC	Roxanne Cech, M.D.	Physician	Greenville	Yes	Unk	Unk	37%	Unk
66	The Free Medical Clinic of Greater Cleveland	Danny R. Williams	Physician	Cleveland	No	4%	90%	2%	5%
6	The Traveling Nurse Practitioner, LLC	Angela J. Schertz RN, CNP	APN	Cuyahoga Falls	No	9%	1%	80%	10%
40	University Medical Associates Diabetes Center	Jay Shubrook DO	Physician	Athens	Yes	30%	0%	35%	35%

06/09/2011

Ohio PCMH Education Pilot Project

Practice and Curriculum Metrics

- 1) Core Clinical Outcome Metrics (taken from Level 2 Metrics as suggested by the Ohio HCCQC MPEPHCI Evaluation Recommendations document)
 - a) Diabetes – Hemoglobin A1c (HbA1c) values
 - b) Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C values
 - c) Blood Pressure values
 - d) Breast Cancer Screening
 - e) Cervical Cancer Screening
 - f) Colorectal cancer screening
 - g) Smoking Cessation Intervention
 - h) Obesity - BMI Assessment
 - i) Behavioral Health
 1. Alcohol/substance screening
 2. Depression screening
 3. Developmental screening
 4. Anti-depression medication management
 - j) Immunizations
 1. Adult: Flu and Pneumonia
 2. Pediatric

- 2) Enhanced Clinical Outcome Metrics (taken from Level 1 & 3 Metrics as suggested by the Ohio HCCQC MPEPHCI Evaluation Recommendations document; require access to claims data)
 - a) Diabetes care – adults who had each of the following
 1. Hemoglobin A1c testing
 2. LDL screening
 3. Retinal eye exam
 4. Medical attention to nephropathy
 - b) LDL screening in patients after acute myocardial infarction, coronary artery bypass or percutaneous coronary interventions
 - c) Beta blocker use after heart attack
 - d) Use of appropriate medications for patients with persistent asthma
 - e) Frequency of imaging for certain types of CT, MRI/MRA, & PET scans
 - f) Frequency of emergency department visits
 - g) Percentage of prescriptions filled using generics
 - h) Frequency of hospitalizations
 - i) Per member per month cost IF case mix can be adjusted appropriately (severity adjustment)

- 3) Satisfaction Survey Metrics (taken from Level 3 Metrics (Patient Experience and Practice Transformation, Sections I, II, and III) as suggested in the Ohio HCCQC MPEPHCI Evaluation Recommendations document)
 - a) Patient Experience - Patient Activation Measurement Survey (PAMS) or Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - b) Provider and Staff Satisfaction – (consider using Maslach Burn Out Inventory tool)
 - c) Student satisfaction survey - TBD

- 4) Access to Care Metrics
 - a) FTE – Full Time Equivalent for each working provider. Number of annual paid hours divided by 2,080.
 - b) Average Visits per day per provider - Total patients seen in a month divided by the number of days worked.

- c) Provider Panel Size - Number of patients that are assigned to each primary care provider in the practice. (unique patients in an 18 month period).
 - d) Same Day Availability - An average of the percentage of open appointment slots at the beginning of the day for a five consecutive day period.
- 5) Practice Operations/Practice Financials Metrics (will only be reported in aggregate)
- a) Average Net Medical Revenue per Clinician - Average monthly clinician revenue collected from all sources for patient care minus refunds.
 - b) Practice Overhead as a % of Net Medical Revenue - The percentage of all costs (excluding clinician salary and benefits) as a % of net medical revenue (revenue collected from all sources related to patient care minus refunds).
 - c) Employee Salaries and Benefits as a % of Net Medical Revenue - All salaries, bonuses, benefit costs (insurance, travel, education, etc.) of employees (not providers) as a % of net medical revenue (revenue collected from all sources related to patient care minus refunds).
 - d) Clinician Compensation - Annual
- 6) Metrics related to Curriculum and Future Clinician Training
- a) Construct a disease self-management module for COPD (or any other common chronic condition) using the techniques of motivational interviewing (or other model).
 - b) Participate in trans-disciplinary team meetings focused on the care of patients.
 - c) Participate as a team member in at least one project involving continuous practice improvement.
 - d) Employ culturally and developmentally appropriate screening tools to identify behavioral health problems in the primary care setting.
 - e) Under the direct supervision of a preceptor, address the issue of a medical error with a patient. (Alternative: Role-play such an encounter with other students and a faculty facilitator.)
 - f) Discuss with the preceptor the effective integration of current guidelines and evidence with respect to health promotion and disease management for short and long-term patient care.

PCMH Curriculum
Goals, Objectives, and Integrated Learning Strategies
FINAL

Goal 1: Students will understand the importance of a *personal clinician* (a clinician who knows each patient as an individual) to the health of individual patients and the population as a whole.

Objectives: By the end of this learning experience students will:

1. Serve as their patients' advocate for their health care needs and resources within the practice and the health care system.
2. Establish professional relationships with patients by providing first contact care.
3. Maintain professional relationships with patients by providing continuity of care in their patient population.
4. Develop collaborative, caring relationships with a panel of patients.

Integrated Learning Strategies:

1. After appropriate review of the chart and other records and discussion (if appropriate) with preceptor, provide 1st contact care to the patient.
2. Demonstrate effective listening, observational and communication techniques in all encounters.
3. See or communicate with patients in follow up to provide continuity of care.
4. Advocate for patient's health care needs by collaborating with practice staff to set up tests, make referrals, and follow up on diagnostic studies and reports from consultants.
5. Examine and explain a case where a patient having a personal clinician improved their care by avoiding an ER visit, a re-admission or unnecessary admission, unneeded tests, or unnecessary procedures.
6. Contrast the care provided by a personal clinician (who knows the patient) to the care received by a patient who does not have a personal clinician or a medical home.

Goal 2: Students will recognize the importance of *patient centeredness* in successful health care outcomes.

Objectives: By the end of this learning experience students will:

1. Care for patients and families with sensitivity to each patient's culture.
2. Develop an evidence-based personal care plan for at least one patient.
3. Assess the self-management needs of patients with chronic illness.
4. Assist patients in connecting with peer support groups or other appropriate community resources.
5. Support patients' health behavior change.
6. Assist patients in developing a plan for disease prevention and health maintenance.
7. Assist patients with developing effective action plans for self-management activities.

Integrated Learning Strategies:

1. Apply strategies to improve the usability of health information when communicating with persons of low health literacy including limiting the messages in one conversation episode, using plain language, and focusing on actions to be taken (based on *Guide to Health Literacy* published by USDHHS).
2. Design practice, administrative, and organizational accommodations that contribute to a culturally competent/responsive practice setting including but not limited to language appropriate written materials, linguistic competencies in front office staff, and a welcoming cultural atmosphere.
3. Construct a disease self management module for COPD (or any other common chronic condition) using the techniques of motivational interviewing (or other model).

Goal 3: Students will recognize the importance of the *team approach* to patient care in successful health care outcomes.

Objectives: By the end of this learning experience students will:

1. Describe the trans-disciplinary team approach to patient care within the scope of practice.
2. Learn about the team approach to patient care.
3. Examine the roles of trans-disciplinary team members as they apply to the scope of practice.
4. Translate the roles of trans-disciplinary team members into functionality of patient care assignments.
5. Incorporate trans-disciplinary teamwork in the care of patients with a variety of diagnoses, complexities and situations.
6. Consult with other healthcare and academic institutions with experience in PCMH model.
7. Effectively become a trans-disciplinary team member, operationalizing the PCMH model.

Integrated Learning Strategies:

1. Participate in trans-disciplinary team meetings focused on the care of patients.
2. Lead at least one of these team meetings.
3. Participate as a team member in at least one project involving continuous practice improvement.
4. Analyze with other students effective and ineffective team meetings observed.

Goal 4: Students will recognize the importance of *integrated, coordinated care* in successful health care outcomes.

Objectives: By the end of this learning experience students will:

1. Follow-up on referrals, labs, x-rays, and other patient services.
2. Manage communications with consultants and other parts of the health care system.
3. Manage mental and behavioral issues for patients in collaboration with mental/behavioral health care providers in the practice and/or community.
4. Communicate the patient care plan to those involved in the patient's care according to the patient's wishes and in accordance with applicable laws governing personalized health information (PHI).

Integrated Learning Strategies:

1. Utilize available technology for follow up on labs and other services to facilitate timely treatment and minimize errors.
2. Compose complete written referrals to specialists and other members of the health care team that include a statement of the expectation of follow up communication.
3. Employ culturally and developmentally appropriate screening tools to identify behavioral health problems in the primary care setting.
4. Classify local behavioral health resources that may provide consultation, co-management, or full management of behavior health problems based on condition, severity, and patient preference.
5. Translates policies, laws, and rules regarding confidentiality to empower patients to use selective disclosure with family members/caregivers to preserve privacy yet facilitate their (family/caregiver) appropriate involvement in the treatment plan.

Goal 5: Students will apply the principles and practices of evidence-based *population management* and public health in an equitable manner to advance the health of the community.

Objectives: By the end of this learning experience students will:

1. Manage communications with community agencies and health departments.
2. Manage patient care effectively, utilizing community resources appropriately.
3. Utilize IT tools to manage populations of patients within the practice.
4. Develop an action plan for those patients whose outcomes are not improving.

Integrated Learning strategies:

1. Describe a patient population using NCHS online data tools.
<http://www.cdc.gov/NCHS/>
2. Participate in a longitudinal experience by spending a day (weekly, monthly, quarterly) at a community agency or health department.
3. Demonstrate the ability to use the chronic disease management strategies of www.improvingchroniccare.org.
4. Describe the practice's patient population based on zip code, and evaluate the SES indicators in each zip code.
5. Develop a disease registry of a common chronic disease from a practice's patient database.
6. Participate in managing a cluster of patients over time with a selected chronic disease.
7. From the chosen chronic disease, evaluate, choose, and/or develop patient self-management support tools based on evidence based medicine/guidelines.
8. From the chosen cluster, maintain ongoing contact through secure email or equivalent.
9. Explain the laws pertaining to communication of personal health information (PHI).

Goal 6: Students will recognize the importance of *access to care* that is high in quality and equitably applied in a way that meets the needs of the patient with respect to time of service and manner of delivery.

Objectives: By the end of this learning experience students will:

1. Facilitate continuity of care to meet patients' needs in a timely and agreeable manner.
2. Manage patient problems by means of asynchronous communications.
3. Communicate effectively with patients.

Integrated Learning Strategies:

1. The student will calculate a continuity index for the practice and present the results to the team.
2. Under the supervision of the preceptor, the student will communicate with patients by email – determining which questions are appropriate for email management and which require face-to-face care.
3. The preceptor will directly observe the student interacting with patients and will give feedback and instruction regarding the student's performance.

Goal 7: Students will recognize the importance of continuous *quality improvement*, using best current evidence to develop and refine best practices for patient care.

Objectives: By the end of this learning experience students will:

1. Use patient and practice data to improve patient care.
2. Participate in practice improvement meetings.
3. Participate with the team to act on patient safety and quality data.
4. Analyze team behaviors that strengthen or weaken patient safety and quality of care.
5. Provide appropriate disclosure to patients when errors occur.
6. Seek research that provides evidence for improved outcomes.

Integrated Learning Strategies:

1. Implement a quality improvement project and evaluate its effectiveness.
2. Participate with other students in small group discussions comparing the practice improvement meetings you have attended.
3. Identify a patient safety issue in the practice and design a program to address this issue.
4. Participate with other students in small group discussions regarding individual behaviors (positive and negative) you have observed at the team meeting you have attended.
5. Under the direct supervision of a preceptor, address the issue of a medical error with a patient. (Alternative: Role-play such an encounter with other students and a faculty facilitator.)
6. Conduct a literature search on a quality improvement topic of interest to the practice and present it at a team meeting.
7. Analyze patient quality and safety data concerning a common condition seen in the practice.
8. Evaluate a customer satisfaction survey.
9. Participate with other students in a small group discussion of the meaning of a “just culture” for delivering health care.

Goal 8: Students will understand the importance of *information systems* to the functionality of the patient-centered medical home.

Objectives: By the end of this learning experience students will:

1. Use an evidence-based approach for chronic disease management and preventive health care.
2. Use evidence-based decision support tools at the point of care in real time during patient visits.
3. Improve patient outcomes by utilization of information systems in patient care.

Integrated Learning Strategies:

1. Discuss with the preceptor the effective integration of current guidelines and evidence with respect to health promotion and disease management for short and long-term patient care.
2. Identify in the practice resources for decision-supports and evidence based guidelines.

3. Create decision-support guides using national guidelines for a specific disease and health promotion topic.
4. Integrate decision-support tools with patient management at the point of care.
5. Perform a limited chart review to identify opportunities for improved quality through the use of decision-supports for a specific chronic disease or health promotion topic.
6. Identify an existing decision-support tool to address the information found in the chart review.
7. Describe the role of electronic medical records, decision-supports, and data collection in quality improvement measures.
8. Identify and discuss national, state and local quality improvement initiatives utilizing decision supports, EMR and other information systems.

Goal 9: Students will demonstrate appropriate *leadership skills*.

Objectives: By the end of this learning experience students will:

1. Interact respectfully with all members of the health care team.
2. Identify opportunities for improving patient care.
3. Use leadership styles appropriate to various situations.

Integrated Learning Strategies:

1. Demonstrate the following communication skills: active listening, reflection, clarification, summation, empathy.
2. Suggest the topic for a quality improvement project in your practice.
3. Lead that quality improvement project.
4. Participate with other students in small group discussions regarding the appropriate situations for the use of the following leadership styles: democratic, directive, laissez-faire, delegating, coaching.
5. Discuss with your preceptor leadership styles you have observed in various team meetings in your practice.
6. Along with your preceptor, observe a videotape of yourself in a patient encounter and self-critique the effectiveness of your communication skills.

Goal 10: Students will *advocate* for the Patient Centered Medical Home (PCMH) as a means of improving the health of the community.

Objectives: By the end of this learning experience students will:

1. Understand the basic concepts of the PCMH.
2. Encourage colleagues to use PCMH concepts in their own practices.

Integrated Learning Strategies:

1. Conduct a literature search on the PCMH and its effect on health care quality and cost.
2. Present a brief summary of the PCMH at one of your team meetings.
3. Participate with other students in small group discussions regarding the pros and cons of the PCMH.
4. Discuss the pros and cons of the PCMH with your preceptor.
5. Attend a professional association meeting where the PCMH is discussed.

House Bill 198 Patient-Centered Medical Home Education Pilot Project
Final Draft
Case for Support
June 10, 2011

In June 2010 the Ohio General Assembly passed nationally unique, path breaking legislation, House Bill 198 or the Patient-Centered Medical Home Education (PCMH) Pilot Project. The legislation was unique in three critical ways. First, it emphasized both nurses and physicians, fostering cooperation in the development of the pilot across and among both groups. Second, it emphasized both education and the creation of more PCMH practices. This twin emphasis married the goal of spreading the development of the PCMH model of care to regions beyond Ohio's existing PCMH pilot program with the need to train the next generation of providers in this model of care delivery. Third, it focused on spreading the PCMH model and training to educationally-affiliated physician and Advanced Practice Nurse-led practices in Ohio's smaller urban, rural, and Appalachian communities. These areas are often less able to respond to national initiatives.

Secondary to budget challenges in Ohio, H.B. 198 included no direct funds to support the initiative. The legislation created the PCMH Education Advisory Group (EAG) charging it to work to find financial support for the project. The legislation granted the EAG the authority to apply for grants, seek federal funds, seek private donations, or seek any other type of funding that may be available for the pilot project.

The EAG secured \$300,000 in funding from the Ohio Health Care Coverage and Quality Council to support the development phase of the project. The EAG is now seeking funds to support the implementation of the PCMH Education Pilot Project. This document provides a case for support for the PCMH Education Pilot Project.

What are the components of H.B. 198's PCMH Education Pilot Project?

House Bill 198 recognized the importance of improving timely access to care, better patient outcomes, and enhanced quality in a manner that helps slow the rate of increase in the cost of health care. To achieve this end, House Bill 198 supports the spread of the patient-centered medical home model of care. Moreover, the legislation recognized the need to develop a new way to train clinicians so they can work under this model of care, including working in a team-based approach. Finally, the legislation placed importance on spreading this model to physician and nurse-led practices and to training the next generation of primary care providers.

To advance the legislation's goals, its authors created the PCMH Education Advisory Group (EAG) to administer the project, charging it to:

- Secure 44 primary care practices to participate in the pilot
 - These practices must each be educationally affiliated with at least one of the specified four medical schools or five nursing schools

- At least four of the practices must be led by an Advanced Practice Nurse (APN)-led and no more than 40 of the practices can be physician-led
- Secure funding to support the pilot projects by providing:
 - comprehensive training on the operation of a PCMH, including assistance with leadership training, scheduling changes, staff support, and care management for chronic health conditions
 - reimbursement for not more than 75% of the cost incurred in purchasing any health information technology required to convert to a PCMH, including the cost incurred for appropriate training and technical support
- Develop a new curriculum for Ohio's medical schools, nursing schools, and primary care residencies that prepare APNS and physicians to practice within a PCMH model of care
- Develop a proposal for the creation of a primary care medical student and primary care nursing student component of the Choose Ohio First scholarship program.

What is a Patient-Centered Medical Home (PCMH)?

The patient-centered medical home is an emerging best practice approach to changing the delivery and orientation of primary care. A PCMH is a health care setting that facilitates partnerships between individual patients, their personal clinician, and their family, when appropriate. It also is to foster more effective care coordination, especially between primary care and specialty care.

The Medical Homes Taskforce of the Ohio Health Care Coverage and Quality Council (HCCQC) passed the following recommendation for the Ohio medical home definition and characteristics in January 2010, which the Council adopted.

Definition¹: A medical home is an enhanced model of primary care in which care teams attend to the multi-faceted needs of patients, providing whole person comprehensive and coordinated patient-centered care.

Characteristics of Medical Homes in Ohio²:

1. **Patient-Centered:** Each patient has access to care based on an ongoing relationship with a licensed clinician³ who provides continuous and comprehensive primary care;

¹ This definition was adopted by the National Academy of State Health Policy (NASHP).

² These characteristics are largely modeled after the *Joint Principles of the Patient Centered Medical Home*, endorsed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association.

³ For the purpose of this recommendation, "licensed clinician" is a physician licensed under Chapter 4731 of the Revised Code, and any other health care professional, acting under their respective licensure statutes. This recommendation is not intended nor shall be construed to either expand or limit the scope of a health care professional while providing services to patients within a medical home.

2. **Team-Based Approach:** The model employs a multidisciplinary team of individuals, including the patient, who is the center of the care team, and collectively take responsibility for the ongoing needs and care of the patient. Patients actively participate in decision-making and feedback to ensure expectations are met;
3. **Whole Person Orientation:** The licensed clinician provides for each patient's comprehensive health care needs or appropriately arranges care with other qualified professionals. This includes care for all stages of life, including acute, chronic, preventative and end of life care;
4. **Care Coordination and Integration:** Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community (family, public, and private [for-profit and non-profit] community-based services). Care is facilitated by the use of office practice systems such as registries, information technology, health information exchange, and other systems to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner;
5. **Quality and Safety:** Quality and safety are hallmarks, including clinician advocacy for patient-centered outcomes driven by a compassionate, robust partnership among licensed clinicians, patients, and the patient's family. Evidence based care and clinical decision-support tools guide decision making, and clinicians accept accountability for continuous quality improvement through voluntary engagement in performance measurement systems. Information technology is utilized to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by a nationally recognized entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model;
6. **Enhanced Access:** Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, licensed clinicians, and staff;
7. **Payment:** Payment appropriately recognizes the added value provided by care coordination, care that falls outside of the face to face visit, health information technology for quality improvement, enhanced communication access, work associated with remote monitoring of clinical data, and case mix differences.

The National Committee for Quality Assurance (NCQA) has identified the following criteria for recognizing a practice to be a medical home:

1. **Enhance Access/Continuity**
 - a. Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours;
 - b. The practice provides electronic access;

- c. Patients may select a clinician;
 - d. The focus is on team-based care with trained staff.
2. **Identify/Manage Patient Populations**
 - a. The practice collects demographic and clinical data for population management;
 - b. The practice assesses and documents patient risk factors;
 - c. The practice identifies patients for proactive and point-of-care reminders.
 3. **Plan/Manage Care**
 - a. The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems;
 - b. Care management emphasizes pre-visit planning; assessing patient progress toward treatment goals; and addressing patient barriers to treatment goals;
 - c. The practice reconciles patient medications at visits and post-hospitalization; and the practice uses e-prescribing.
 4. **Provide Self-Care Support/ Community Resources**
 - a. The practice assesses patient/family self-management abilities;
 - b. The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources;
 - c. Practice clinicians counsel patients on healthy behaviors;
 - d. The practice assesses and provides or arranges for mental health/substance abuse treatment.
 5. **Track/Coordinate Care**
 - a. The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals);
 - b. The practice follows up with discharged patients.
 6. **Measure/Improve Performance**
 - a. The practice uses performance and patient experience data to continuously improve;
 - b. The practice tracks utilization measures such as rates of hospitalizations and ER visits;
 - c. The practice identifies vulnerable patient populations;
 - d. The practice demonstrates improved performance.

The difference in the PCMH model from the current practice of primary care, includes moving:

- a.
 - i. **From** patients are those who make appointments **to** patients are those who are members of the practice's medical home;
 - ii. **From** patients' chief complaints for visit determines care **to** systematically assess all patients' health needs to plan care;
 - iii. **From** care determined by today's problem and time available for visit **to** care determined by proactive plan to meet patient needs without visits;

- iv. **From** care varies by scheduled time and memory or skill of clinician **to** care is standardized according to evidence-based guidelines;
- v. **From** patients are responsible for coordinating own care **to** a prepared team of professionals who help coordinate total patient care;
- vi. **From** clinicians knowing that they deliver high quality care because of their training **to** measure quality and make rapid changes to improve it;
- vii. **From** acute care delivered by next available appointment and walk-ins **to** acute care is delivered by open access and non-visit contacts;
- viii. **From**” it is up to patient to tell us what happened to them” **to** practice tracks tests and consultations and follow-up after ED and hospitals;
- ix. **From** clinic operations center on meeting the clinician’s needs **to** multidisciplinary team works at the top of their licenses to serve patients.

Why the interest in Patient-Centered Medical Home model of care?

Four mutual reinforcing needs underlie the interest in the PCMH model of care. These needs are:

- To improve the patient’s care experience so they can access timely, appropriate care at the right place versus delaying care or seeking it at the emergency room;
- Re-establish the importance of primary care as the foundation of the medical care system;
- To reinvigorate the delivery and financing of primary care so that it is attractive to physician and nurse clinicians;
- More effectively address the health cost challenges that threaten sustainability of all forms of health care coverage, from employer-based plans to individual private plans, to Medicare, and Medicaid.

On the workforce and patient satisfaction front, report after report warns of a coming primary care provider shortage, especially in rural and other underserved areas, and of growing frustration among patients in getting access to timely care. Ken Bertka, MD, FAAFP, CPHIMS, Catholic Health Partner’s VP for Physician Clinical Integration, identified the following challenges to the existing way of delivering primary care:

- Estimated shortage of between 40,000 and 60,000 primary care physicians over the next 10 years, with up to 30% of current primary care physicians reporting that they are likely to leave their practices in the next two years;
- Current primary care practices lack effective care coordination and population management;
- Appointment wait times are too long;

- Too much time is spent on acute care 49% versus 36% for chronic care and 15% for preventive care compared to the recommendations to meet care guidelines (49% for chronic care, 34% for preventive care, and 17% for acute care);
- Being able to meet recommended care guidelines requires more chronic care management and team-based care.

On the health care cost front there is growing appreciation that the current system focuses on sick care over health care. Many studies, such as an analysis by the Midwest Business Group on Health, find that upwards of 30% of existing health spending adds no value or creates negative value. The structure of the existing delivery system contributes to this wasted spending because it fosters ineffective chronic care coordination, too many inappropriate visits to the emergency room, too much duplicative, unneeded testing, too many hospitalizations, and too many rehospitalizations. This structure undervalues primary care and fails to have in place the care supports needed to keep people healthy and out of more expensive care settings, especially for those with existing chronic health problems.

This problem is especially critical in Ohio. Data from the Agency for Healthcare Research and Quality's (AHRQ) annual report shows that Ohio consistently ranks at the low average or below for most of its health care measures, especially those measures affected by care in the primary care setting. This report ranks Ohio as:

- Weak for preventive, chronic, and cancer care;
- Very weak for diabetes care and home health care;
- Low average for maternal and child health care and respiratory diseases;
- High for hospital care and cardiac care.

Harold Miller, who served as Ohio's national expert consultant at the December 2010 Ohio Payment Reform Summit, reported on Ohio's care challenges, noting that Ohio:

- Ranks 44th in the rate of people using emergency rooms;
- Ranks 42 in the rate for preventable hospitalizations for ambulatory sensitive conditions for its Medicare population;
- Has a 25% hospital 30-day readmission rate across all its hospitals.

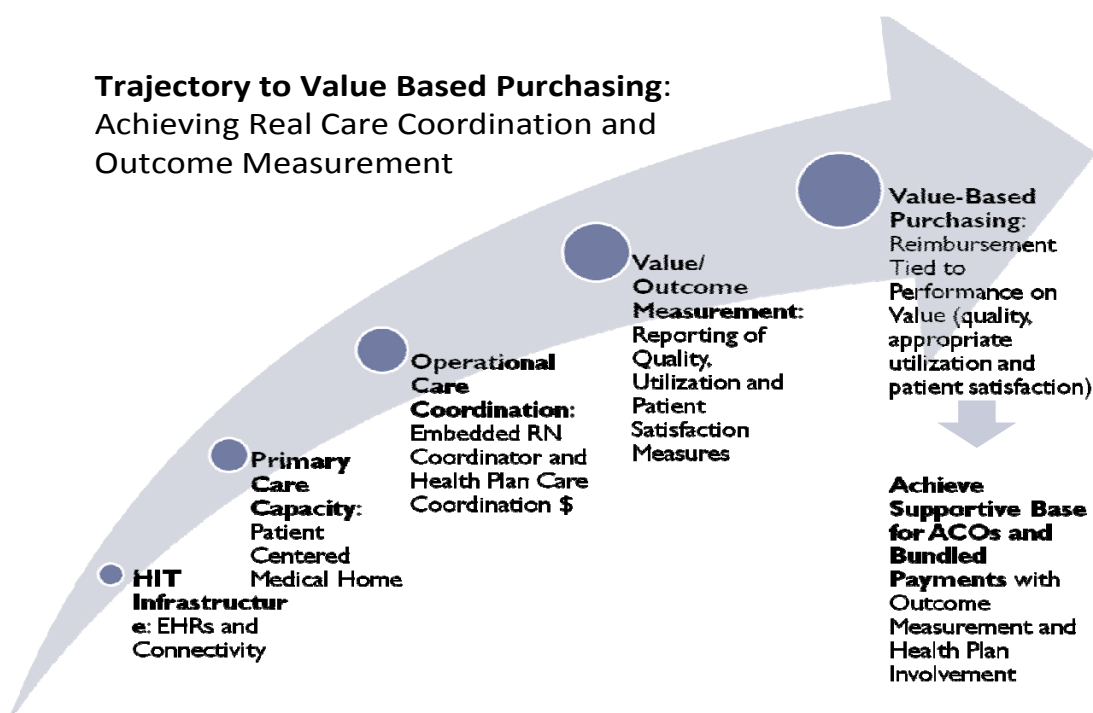
The Commonwealth Fund creates a State Scorecard that compares states on five different dimensions of care. One element of the scorecard identifies how a state would perform if it provided care at a rate similar to the best performing state versus some ideal benchmark. According to this comparison Ohio would have:

- 44,865 fewer preventable hospitalizations for ambulatory sensitive conditions for its Medicare population (savings of \$276,103,274);
- 13,124 fewer hospital readmissions for its Medicare population (savings of \$162,254,116);
- 6,630 fewer long-stay nursing home patients being hospitalized (savings of \$49,213,233);
- 200,731 more adults with diabetes receiving all three of recommended diabetes care services;

- 4,385 fewer premature deaths from causes that are potentially treatable or preventable with timely and appropriate health care.

Based on Ohio data, and similar national data, multiple commission reports and health reform initiatives have identified PCMH as a critical building block to create an affordable and sustainable health care system that truly meets the needs of patients and their providers. In Ohio, these reports and initiatives include Ohio Healthcare Quality Improvement Plan, the work of the Ohio Healthcare Coverage and Quality Council Medical Homes Taskforce, House Bill 198, and Ohio's 2012-2013 state budget that includes an emphasis on fostering health homes.

The Hudson Valley Initiative provides a nice image on the five critical stages for creating effective, value-based purchasing needs for real care coordination and outcomes improvement. The PCMH model of care is the second of the five stages, serving as a vital underpinning to achieving the other stages (see Figure 1).



The PCMH model of care also possesses an important economic development component. Paul Grundy, MD, MPH, FACOEM, FACPM, IBM's Director of Healthcare Transformation for IBM Global Wellbeing Services and Health Benefits, co-founder of the Patient-Centered Collaborative, and a national advocate for PCMH, made several presentations on PCMH in Ohio in May 2011. In these presentations Dr. Grundy emphatically stated that IBM and other large businesses are increasingly making operation location decisions with health care cost considerations in mind. To that end, he stated that the existence of a well functioning PCMH model of delivery has become one

of IBM's key factors in selecting where to locate new call centers and other operation centers.

To underscore this point Dr. Grundy shared a conversation he had with the leadership of an Ohio hospital with the nation's highest rate for cardiac catheter procedures. According to Dr. Grundy, he told the hospital that, "he would never locate new employment in a community that touted its heart specialty care. Instead, his company will locate new employment in communities that emphasize and can demonstrate reducing the need for heart specialty care."

What is the evidence supporting the value of the Patient Centered Medical Home?

The PCMH model of care is a relatively recent development. Therefore, is there research yet to support investing in this model of care?

Such information is emerging. These findings include:

- TransforMed, a leading PCMH practice transformation facilitator who participated in the two-year national demonstration project, found in its work with 36 unrelated, independent practices under the existing fee-for-service payment system:
 - 58% increase in clinician satisfaction;
 - 66% increase in staff satisfaction;
 - 11% increase in practice revenue and;
 - 14% increase in clinician salaries.
- North Carolina Medicaid found a 40% decrease in asthma hospitalizations, 15% improvement in diabetes measures, and 16% decrease in ED visits from better care coordination in primary care;
- Commonwealth Fund research found that medical homes that provide a regular source of care, enhanced access and efficient practices help reduce and eliminate healthcare disparities among racial and ethnic minorities;
- Boeing's Seattle PCMH Pilot experienced a 20% reduction in cost;
- Group Health of Puget Sound reduced provider burnout and increased patient satisfaction while achieving the following improvements:
 - 36.3% drop in hospital stays;
 - 32.2% drop in ED use;
 - 9.6% reduction in total cost;
 - 10.5% drop in inpatient specialty care;
 - 18.9% drop in ancillary costs;
 - 15.0% drop in outpatient specialty costs.

What is the status of Phase 1 of the H.B. 198 PCMH Education Pilot Project?

Phase 1 of the H.B. 198 Education Pilot Project took place from December 10, 2010 through June 2011 and was focused on project development. Phase 2 is to begin July 2011, though its effective beginning will depend on the acquisition of funding to support practice transformation.

The EAG received \$300,000 from the Ohio Healthcare Coverage and Quality Council to support the work of Phase 1. With these funds the EAG accomplished the following:

- Created four regional leadership teams (Southeast Ohio; West Central Ohio; Northwest Ohio; and Northeast Central Ohio) affiliated with the specified medical and nursing schools in those regions to:
 - Conduct outreach to recruit applicants to be pilot project sites;
 - Hold learning sessions about the patient-centered medical home;
 - Participate in the evaluation and selection of applicants to be educationally-affiliated pilot sites.
- Held four town hall learning sessions in each region introducing participants to the PCMH model of care;
- Recruited 64 applications for the 44 pilot project sites. Of the 64 practices submitting applications:
 - 44 practices had at least 20% of their patient population being Medicaid or uninsured;
 - 38.5% have more than 30% Medicaid patients;
 - 35% have more than 10% uninsured patients, with 14% having more than 20% uninsured patients and 2 practices with 90% or more uninsured patients;
 - The overall average of Medicaid patients across these practices is 25.1%, while the average of uninsured patients is 13.3% (or a combined average of Medicaid and uninsured patients of 38.1%). This figure understates the total Medicaid percentage because the practices likely identified patients with both Medicare and Medicaid as Medicare patients;
 - 52% serve more than 20% Medicare patients, with over 35% serving more than 30% Medicare patients. Some of these Medicare patients will also have Medicaid coverage (about 18% of Ohio's Medicare population is also on Medicaid);
 - 55% have 5 or fewer providers, with 41% having 3 or fewer providers;
 - 12% have 6 to 10 providers, while 15% have 11 to 20 providers, and 11% have more than 25 providers.
- Reviewed the 64 applications and recommended 44 educationally-affiliated pilot sites for Phase 2
 - Of these practices at least 24.0% of the patient population is Medicaid;
 - 11.4% of the patient population is uninsured;
 - As a result, at least 35.4% of the patient population in these practices are Medicaid;
 - In addition, the practices reported that 24.1% of their patient population is Medicare, of which some portion should also have Medicaid coverage.
- Developed model curriculum to promote training on the PCMH model of care for nursing and physician students and residents which is being shared with deans of colleges of medicine and nursing;
- Developed a set of project metrics to measure success;
- Identified expressed needs for support from potential pilot project sites, including:

- Assistance with understanding how to become a PCMH model of care and then transforming into one;
- Assistance with meeting application requirements for becoming accredited as a PCMH site;
- Assistance in getting data out of EHR systems needed to support PCMH work;
- Assistance in developing performance-based contracts with payers.
- Coordinated regional PCMH teams with regional extension centers charged with providing electronic health record (EHR) technical assistance support to primary care providers to make sure that all applicants had access to this HIT support;
- Developed proposed criteria for a primary care scholarship process to be used at medical and APN schools, which has been shared with the Board of Regents and incorporate into the Choose Ohio First Scholarship program for the coming year
- Developed a sustainability plan and began to secure initial funding support, including:
 - Secured an agreement from Medicaid to pursue federal matching funds for state or other matchable foundation or donated funds;
 - Secured strong interest from a possible major contributor to support Phase 2 work.

During this phase, the EAG and regional leadership learned that Ohio's third party payers are not providing financial support to pilot projects through special payment arrangements, such as a per-member, per month fee. The payers did express willingness to enter into performance-based contracts with any sites. The sustainability plan has taken this learning into its development.

What is the vision for Phase 2 of the H.B. 198 PCMH Education Pilot Project?

The purpose of Phase 2 is to translate the vision of H.B. 198 and the work of Phase 1 into reality. Phase 2's work includes:

- Transforming the selected educationally-affiliated pilot sites into functioning PCMH-based practices over the next two years;
- Training nursing and physician students and residents on practice transformation and PCMH principles;
- Moving forward the incorporation of the PCMH curriculum into the nursing and medical schools across Ohio;
- Creating a PCMH learning community structure that fosters PCMH educational supports from the classroom to the practice, focusing on theory-based learning and evidenced-based practices at the clinician's office.

Phase 2's work also continues to emphasize building a partnership across medical and nursing schools and practitioners to support this transformation.

The phase 2 vision requires assistance in three key areas:

- Practice transformation assistance;
- Education transformation assistance and;
- State level and regional level infrastructure support

Practice Transformation Assistance

Phase 2 supports H.B. 198's call for practice support to achieve two objectives:

1. Reimbursement for not more than 75% of the cost incurred in purchasing any health information technology required to convert to a PCMH, including the cost incurred for appropriate training and technical support; and
2. Comprehensive training on the operation of a PCMH, including assistance with leadership training, scheduling changes, staff support, and care management for chronic health conditions.

The first objective is well underway without requiring additional financial assistance for Phase 2. Fortunately, the federal HITECH initiative already provides financial support to primary care practices for technical assistance on selecting and implementing an EHR and offers incentive payments that are to help cover 85% of the practice's EHR implementation and ongoing use costs. The EAG has already worked to link all of the practices that applied to the Ohio Health Information Partnership and its regional partners to provide this HIT/EHR assistance.

The second objective requires financial support for the pilot practice sites to help transform into well functioning PCMH models of care – the main focus of our project. Based on information gathered from potential applicants, other Ohio PCMH pilot projects, third party payers and Medicaid, national experts in PCMH transformation, and the Ohio Health Information Partnership and HealthBridge, EAG has identified the following project preferences of support for the pilot practices for Phase 2:

- Direct technical assistance for practice transformation from an external vendor to each educationally-affiliated pilot site to assist them in becoming a functioning PCMH:
 - Recommended to provide assistance for two years;
 - Average cost of technical assistance in other Ohio pilot projects is \$10,000 a year.
- Annual stipend for each of the 44 educationally-affiliated pilot sites to cover costs for participating in the project, such as travel and lost of office productivity
- EHR technical assistance support to help practices generate data and needed reports from their EHRs affordably and more easily than what currently exists;
- Contracting technical assistance support to assist practices in entering into effective performance-based contracts with payers;
- Statewide and regional learning sessions among the educationally-affiliated pilot sites, some or all of which may be open to other practices;

- Care coordinators as a key component of the PCMH model of care.

Education Transformation Assistance

Phase 2 will also support H.B. 198's call to transform the education of nurses and physicians toward the PCMH model of care and to increase financial support for students interested in going into primary care.

The Board of Regents reported to the EAG at its May 2011 meeting that funds are available in the Choose Ohio First Scholarship program to support these scholarships. The Board of Regents plans to use the criteria created by the EAG in the design of this component of the Choose Ohio First Scholarship program.

Other education transformation assistance will begin with the educational affiliation between the pilot sites and their affiliated medical or nursing school. Students trained at these sites over the next two years will become exposed to the transformation of care process and the principles of PCMH. Students trained at these sites after two years will work at practices operating under the PCMH model of care. They will also be exposed to a new culture on how to run an effective and efficient PCMH practice.

During the next two years, the nursing and medical schools in Ohio, both those affiliated with the project directly and all the other medical and nursing schools, will be introduced to the proposed PCMH curriculum. Implementation of this curriculum and related learning strategies into practice will begin to take place during this period.

Educational transformation will extend beyond the classroom and the training of students in the educationally-affiliated pilot sites. It will include the development of learning collaboratives among practices to share best practices, learning from each other and from other experiences around Ohio and the country. It will include learning within the practice and continuing educational learning for clinicians who are focused on translating the PCMH model of care into their existing practice of health care.

Infrastructure support

Phase 2 will continue the same organizational infrastructure to support and ensure the effective functioning of the project. The structure includes continuation of the EAG as the overall advisory group on project decisions, continuation of support for the four regional leadership teams, and continuation of a single administrative and fiscal agent to manage ongoing project activities.

The plan is to locate the state level coordination and project management Phase 2 activities to Ohio Colleges of Medicine Government Resource Center (GRC). This shift in administrative management is preferred because the GRC is a public entity that can use funds under its control to draw down federal Medicaid match. The GRC already has other such agreements with Ohio Medicaid and has capacity to manage Phase 2 of the PCMH Education Pilot Project.

State level activities to include:

- Contract management with transformation technical assistance (TA) vendor and any other statewide TA vendors;
- Manage evaluation process (conduct or hire evaluator, setting expectations for evaluation, raising funds for evaluation);
- Submit required reports to project funders;
- Support daily EAG activities and hold EAG meetings;
- Prepare RFPs for vendors and any additional funding requests for state level or regional project funders to support the project;
- Organize and pay for state level project meetings, such as learning collaboratives, webinars, or conferences;
- Hold meetings with health plans to support payment improvements for medical homes (either only HB 198 sites or for all medical homes); and
- Coordinate HB 198 pilot site participation with future medical home-related activities at the state level, such as actions included in the upcoming budget around Medicaid and health homes.

Regional level coordination with pilot practices will continue with the four existing regional entities and include:

- Connect pilot sites to medical and nursing schools for related education affiliation activities;
- Work to promote curricula adoption in participating schools;
- Interact with region's educationally-affiliated pilot sites to identify successes, challenges, concerns, and satisfaction with technical assistance;
- Help solicit local funders to support the project;
- Hold periodic forums with regional pilot sites.

What is the funding strategy for Phase 2?

The funding strategy for Phase 2 is to match state, foundation, or other donated funds with federal Medicaid matching dollars to cover Phase 2's costs associated with practice transformation assistance, educational transformation assistance, and infrastructure support. This matching ability should increase the attractiveness for potential funders because it will increase the value of their contribution.

The federal Medicaid match would be for 50 percent of all allowed direct and in-kind public fund expenditures. The Ohio Department of Job and Family Services' Medicaid Program (Ohio Medicaid) is currently asking the federal government to allow match on all funds expended on a project of importance to Medicaid even if the project serves more than Medicaid patients. Ohio Medicaid reports support from national CMS, but resistance from local CMS auditors to this approach. Ohio Medicaid is working to resolve this issue with a goal to hold a meeting with local CMS auditors in June to confirm the minimum level of support we can expect.

Even if the more ambitious Medicaid match level is not forthcoming, the federal government will match at least those dollars that are directly related to the needs of Medicaid patients (at least 25% of the total funds). The percent of Medicaid patients served will likely increase because some amount of the patients currently identified as Medicare patients will also have Medicaid coverage (dual eligibles), possibly by at least five percent. In addition, the federal government has previously allowed match dollars to be directly allocated to the needs of uninsured patients, since they are at great risk of becoming Medicaid patients, especially after the 2014 expansion (at least another 11.4% of the patient population being served by the educationally-affiliated pilot sites).

Medicaid's support for this work ties to how it fits with Ohio Medicaid's draft quality strategy. Many pieces of this strategy will benefit from an increased number of practices operating under the PCMH model of care and an increase in the primary care workforce trained in the PCMH model of care. Pieces of this strategy that will benefit from more PCMH capacity include:

- Access to services in a timely manner;
- Availability of a robust provider network;
- Care management;
- Health homes;
- Age-appropriate preventive services;
- Prevention and reduction of harm caused by high cost, prevalent conditions such as:
 - Cardiovascular disease
 - Diabetes
 - Asthma
 - Behavioral health
 - Upper respiratory infections
 - High risk pregnancy/premature births
- Integration of care for dual eligible;
- Development of accountable care organizations;
- Meaningful use of electronic health information;
- Support person and family-centered care;
- Promote evidenced-based prevention and treatment practices;
- Improve care coordination;
- Make care safer;
- Develop partnerships to stimulate student interest to serve the Medicaid population, especially in primary care and psychiatry;
- Develop partnerships to practice emerging health care models that require a workforce broader than primary care (e.g. health homes and residency training to practice in health homes).

Because of the tight state budget, Ohio Medicaid and other state agencies do not have the state funds sufficient to support the Phase 2 costs for H.B. 198. Therefore, non-state dollars are to generate the state match support needed to draw down the federal Medicaid match. In addition, non-Medicaid state funds are also needed to cover any costs that

federal Medicaid will not allow. Once these foundation or other private funds get deposited into a state account supporting the project they become public dollars and thus eligible for Medicaid match.

Identified sources of non-Medicaid support for different facets of the project include:

- Other state funds;
- Corporate foundations;
- Ohio-based or national community, family, and health conversion foundations;
- Federal grants;
- Professional associations or organizations with primary care members, such as Ohio Nurses Association, Ohio State Medical Association, Ohio Academy of Family Physicians, Ohio Osteopathic Association, Ohio Association of Community Health Centers;
- Nursing and medical schools;
- Individual donors; and
- Unreimbursed public university finance and administration (F&A) charges tied to this project.

Medicaid will match each dollar contributed from these sources, other than the unreimbursed F&A will generate almost \$3 in federal match. The reason for this level of return on donated dollars is that Medicaid will allow only a 10% indirect rate for any university-based project. The remaining unreimbursed federally approved F&A rate funds, usually at least 40%, become available as state matching funds.

What are the funding needs for Phase 2?

Phase 2 contains several different activities. It is possible to pursue funding for all of these activities together. The project will pursue any such opportunities that arise. It is also possible to fund some of these activities at the beginning and add on other activities as funds develop. The EAG concluded that if the educationally-affiliated pilot sites do not get some degree of immediate, direct support for participating, they have no reason to participate. If there are not any funds for state and regional infrastructure the project cannot operate.

The total initial practice transformation assistance funding goal is \$1.42 million per year or \$2.84 million for the entire project. This funding would cover the costs associated with third party transformation technical assistance, educationally-affiliated pilot site stipends, EHR data reporting assistance, learning collaborative sessions, and performance based contracting assistance, along with the needed state and regional infrastructure support.

Specific funding needs include:

- \$440,000 per year for transformation technical assistance from an external vendor, which equates to \$10,000 per practice per year (\$880,000 for two years);

- \$220,000 per year stipend per participating educationally-affiliated pilot practice (\$440,000 for two years);
- \$300,000 per year for EHR data reporting and accessing technical assistance which may involve the hiring of one system administrator per region to assist 11 practices sites for that region (\$600,000 for two years);
- \$50,000 per year for to cover costs associated with performance-based contracting tool development and training (\$100,000 for two years);
- \$170,000 per year for state level coordination and activities, including costs for evaluation, learning collaborative or other meetings, EAG meetings, fiscal administration, and vendor management (\$340,000 for two years);
- \$240,000 per year for regional level coordination activities (\$60,000 per region per year).

The amount of state funds needed to support the \$1.42 million per year budget depends on what CMS allows for matching related to this project:

- If CMS allows Medicaid federal match on all program expenses then the project needs \$479,250 per year in state and private contributions (\$958,500 for two years);
- If CMS allows Medicaid federal match for only Medicaid and uninsured patients, including dual eligibles, then at least 40.4% of the contributions are matchable and the project will need at most \$1,248,003 per year in state and private contributions (\$2,496,006 for two years);
- If CMS allows Medicaid federal match for only Medicaid patients, including dual eligibles, then at least 29.0% of the contributions are matchable and the project will need \$1,179,007 per year in state and private contributions (\$2,358,014 for two years).

The EAG has prioritized funding direct transformation technical assistance to the educationally-affiliated pilot sites, learning collaboratives, evaluation, and state and regional infrastructure as the most important initial investments. Cost for funding specific components of the technical assistance and infrastructure support can be created on request.

Under this prioritization, the total cost of practice transformation technical assistance, state, and regional infrastructure support would be \$850,000 per year all funds. The amount of state funds needed million per year budget depends on what CMS allows for matching related to this project:

- If CMS allows Medicaid federal match on all program expenses then the project needs \$286,875 in state and private contributions;
- If CMS allows Medicaid federal match for only Medicaid and uninsured patients, including dual eligibles, then at least 40.4 % of the contributions are matchable and the project will need at most \$673,158 per year in state and private contributions (\$1,346,316 for two years);
- If CMS allows Medicaid federal match for only Medicaid patients, including dual eligibles, then at least 29% of the contributions are matchable and the project will

need \$747,044 per year in state and private contributions (\$1,494,088 for two years).

This \$1.42 million budget per year does not include the costs to the Colleges of Medicine and Nursing for educational transformation assistance, such as:

- Implementing PCMH education training into their rotational curriculum and building relationships with the educationally-affiliated practice sites; or
- Costs of implementing the PCMH curriculum into the broader educational structure of the respective Colleges of Nursing and Medicine.

The EAG is continuing to finalize these costs and will incorporate those into an updated total budget and into future funding requests.

This budget also does not include costs for potential additional practice transformation assistance. The EAG has discussed the value of trying to provide care coordination assistance for practices. The EAG continues to identify these additional potential assistance needs and develop a cost and strategy for seeking assistance to provide them.

What is the value of supporting the PCMH Education Pilot Project Phase 2?

Financial support for this project will create the following value:

For patients, the benefits include:

- Increased patient satisfaction;
- Better health quality;
- Better chronic care management;
- Higher rates of preventive care;
- Lower rates of unnecessary hospitalization, rehospitalization, and emergency room trips;
- Better integration of behavioral health and clinical care;
- Reduction in rate of health disparities.

For providers and their practices (APN-led and physician-led,) the benefits include:

- Increased provider satisfaction;
- Increased staff satisfaction;
- Higher retention of providers in primary care practice;
- Improved practice and provider income, even under the existing payment system;
- Improved readiness to participate in new payment strategies that reward performance and being a PCMH.

For health purchasers (public and private), the benefits include:

- More Ohio practices operating according to the PCMH model available to partner with health purchasers;

- More practices able to participate in both performance-based contracting payment;
- More practices ready to participate in forthcoming Ohio medical-home related activities, such as Medicaid's health home initiative, and private sector plan efforts;
- Better integration of behavioral health and clinical care;
- More providers being trained to work in or with the PCMH model of care.

For employers, the benefits include:

- Reduction in health costs that should slow growth in health care premiums;
- Improved health care for workers that should produce a more productive workforce, especially for workers with chronic conditions.

For primary care capacity in Ohio, the benefits include:

- More practices to serve as leaders to support next wave PCMH transformation for additional practices;
- Increased Ohio-based capacity of people trained to assist practices in practice transformation to a medical home model;
- Increased capacity of sites to teach next generation of providers to practice as a medical home or to interact with a medical home (if the provider becomes a specialist versus a primary care practitioner);
- Improved practice environment for primary care providers that should encourage more students to enter into primary care and existing providers to stay in primary care.

For Ohio's Colleges of Nursing and Medicine, the benefits include:

- Become a national leader in the training of primary care providers in the PCMH model of care;
- Colleges become a national leader in the training of specialty care providers in the PCMH model of care that will assist them in working more effectively with PCMH practices;
- Address and close the nationally recognized gap between Colleges of Nursing and Medicine and the day-to-day practice of medicine and nursing;
- Be better prepared for new accreditation requirements related to training providers in the PCMH model of care.

For Ohio's overall health system, the benefits include:

- More providers willing to work in primary care;
- More effective delivery of primary care that results in greater access to primary care for acute care, preventive care, and chronic care;
- More time for practices to focus on chronic care and preventive care;
- Better overall care with lower rates of hospital admissions, readmissions, and emergency room visits;
- Lower total health costs;
- Creation of needed foundation to allow for further evolution to a value-based health system;
- Reduction in rate of health disparities;
- Ability to move Ohio to higher performance on measures such as Commonwealth's State Scorecard or AHRQ's State Snapshots.

For Ohio's overall economy and jobs creation, the benefits include:

- Higher value health system that makes Ohio a more attractive place for firms to locate jobs or retain jobs given that:
 - Quality of life is an important decision for firms when they make final decision among location options of which includes access to high quality primary care and low cost, effective care evidenced by IBM recent choice to locate a site with 1,300 jobs in Iowa because of its integrated health systems and higher availability of medical home practices;
 - An increasing number of large employers are requiring that their health plans only contract with PCMH practices;
 - Creating an attractive health care system in rural and Appalachian Ohio that should improve the willingness of businesses to locate new facilities in those parts of Ohio;
 - Lowering health cost pressure can make firms more open to hiring more employees overall, and more full-time employees versus part-time employees.

- More cost effective Medicaid and other government programs that should slow rate of growth in Medicaid spending and reduce revenue challenge of the program, making it easier to invest state dollars in other programs.

- Creation of more a attractive practice environment for primary care providersby:
 - Attracting of primary care providers from other states to work in Ohio;
 - Increasing primary care jobs in underserved areas;
 - Encouraging more Ohio-trained providers to work in primary care.

What benefits will financial partners of the PCMH Education Pilot receive?

Benefits that financial partners of the PCMH Education Pilot will receive, in addition to helping a worthy cause include:

- Named recognition as supporters of the project on all project materials, with recognition potentially being identified as bronze, silver, gold, and platinum by level of funding support;
- Named recognition in press release announcing funding support given to HB 198 at the state level, in local papers in the pilot areas, and in announcements sent to provider and other associations for inclusion in communications to their members;
- Special named recognition for funders that fully or significantly sponsor a specific component of the project, such as evaluation or practice transformation assistance;
- Invitation to participate in all project-related events;

While HB 198 prescribes which organizations can officially be part of the EAG, other participation options could be participating in a grant oversight steering committee, an EAG taskforce or workgroup, and/or having a non-voting status to participate in EAG meetings Updates on project developments, including interim reports