



Central Ohio Patient-Centered Medical Home Project
Collaborative Learning Session Record
February 10, 2010 8:30 AM-11AM

...creating access to the right health care, at the right time, in the right place

Discussion Purpose

- a) Learn how other communities are advancing patient-centered medical homes
- b) Collectively explore what specific patient engagement strategies – from employer incentives to ongoing patient care plans – will support successful implementation of patient-centered medical homes in our community

Participants

Peter A. Accetta, MD, *The Medical Group of Ohio*
Berna Bell, *Ohio Hospital Association*
Bryan Borello, *Pfizer*
Linda Clem, *Mount Carmel Health Providers*
Craig N. Crager, *OPERS*
Barb Cygan, *Medical Mutual of Ohio*
Pam Doseck, *The Ohio State University*
Regina Drzewiecki, *City of Upper Arlington*
Meghan Dougherty, *Employers Health Coalition of Ohio*
Mary Ellis, *Ohio Department of Administrative Services*
Toni Fortson-Bigby, *CareSource*
Reed Fraley, *Ohio Hospital Association*
Judy Gerber, *Medical Mutual of Ohio*
Janet Grant, *CareSource*
Pamela Gray, *OSU Internal Medicine, LLC*
Tom Hadley, *Wells Fargo Insurance Services*
Ben Humphrey, MD, *The Medical Group of Ohio*
Isi Ikharebha, *Physicians Free Clinic/Voluntary Care Network*
Carrie Jacobs, *Nationwide Better Health*
David Kageorge, MD, *Mount Carmel Health Providers*
Kim Keinath, *Access HealthColumbus*
Cathy Levine, *Universal Health Care Action Network Ohio*
Lisa Kaiser, *Health Action Council*
Kate Mahler, *Ohio Academy of Family Physicians*
Greg McMorrow, *IBM*

Marcas Miles, *Employers Health Coalition of Ohio*
Dan Okonak, *Molina Healthcare of Ohio*
Kevin Orr, *Pfizer*
Kenneth Payne, *Medical Mutual of Ohio*
Brian Pierson, *Mount Carmel Health*
Malcolm Porter, *Access HealthColumbus consultant*
Angelique Price, *Metropolitan Family Care*
Charity Rausch, *Employers Health Coalition of Ohio*
Mark Ridenour, *The Ridenour Group*
Matt Schull, *Pfizer*
Thomas Sherrin, *OhioHealth*
Scott Solsman, *Franklin Co. Cooperative Health Benefits Program*
Rick Snow, DO, *Applied Health Services*
Mike Stull, *Employers Health Coalition of Ohio*
Gary Thurnauer, *Pfizer*
Karen Towslee Keenan, *OSU Primary Care Network*
Lori Vagi, *Mount Carmel Health Partners*
Bruce Wall, MD, *OSU Health Plan*
Susan Webb, *OSU Internal Medicine, LLC*
Beth Weinstock MD, *Village Family Medicine*
Daniel Wendorff, MD, *Mount Carmel Health System*
Becky Wilkins, *OSU Rardin Family Practice*
Donna Woods, *Gladden Community House*
J. William Wulf, MD, *Central Ohio Primary Care*

Keynote Speaker

Paul Grundy, MD, *IBM* (Dr. Grundy is available for this event through the generosity of Pfizer and the Employers Health Coalition of Ohio)

Hosted By

Jeff Biehl, *Access HealthColumbus*

I. WELCOME, FRAMING & FLOW:

Jeff Biehl welcomed everyone and framed the meeting by reviewing today's discussion purpose, our current health care deficiencies and what must be done to address these deficiencies. The objectives and focus of the Central Ohio Patient-Centered Medical Home Project was presented along with a summary on measuring financial return on investment.

II. LEARNING FROM OTHER COMMUNITIES – PAUL GRUNDY, MD

Mike Stull introduced Paul Grundy, MD, IBM Corporation’s Global Director of Healthcare Transformation. Dr. Grundy presently serves on The Medical Education Futures Study National Advisory Board and is president of the Patient-Centered Primary Care Collaborative.

Dr. Grundy gave a presentation on Using the Patient Centered Medical Home for Break Through Performance and shared results from various patient-centered medical home pilots from around the country.

The following is a summary of lessons learned from Dr. Grundy’s presentation:

- *It is hard to implement patient-centered medical homes with a single health plan providing the financial support for care coordination payments to medical homes*
- *This innovation is about movement and change*
- *Focus on early adopters and not everyone at once*
- *Don’t worry about all employers/employees having to be in on this change on Day 1*
- *Trusted clinician = healing relationship*
- *Care coordination is most successful the closer the care coordinator is to the point of care*
- *ROI: reducing non-urgent ER visits by 7-8%, reducing preventable hospitalizations by 8-10%*
- *Employers are choosing where to put their employees based on the value of local health care system – patient-centered medical homes contribute in improving this value*

III. EXPLORING & SHARING PATIENT ENGAGEMENT STRATEGIES

Participants were asked to join one of three discussion groups and work together to identify top two patient engagement strategies.

<i>What will my employer/purchaser need to do to get my attention & participation?</i>	
Hosted by Mike Stull	<ul style="list-style-type: none"> A. Flexibility in communications <ul style="list-style-type: none"> i. The key to effective communication with patients is that it comes from a trusted source B. Plan design incentives <ul style="list-style-type: none"> i. No/lower co-pays for patient-centered medical homes ii. Build patient responsibility into plan design to improve engagement

<i>After I have selected my patient-centered medical home, what will I experience?</i>	
Hosted by Jeff Biehl	<ul style="list-style-type: none"> A. Care coordinator as part of physician led team: <ul style="list-style-type: none"> i. Finding the ‘right’ person with skills and personality to build trusting relationship with patients ii. Must have a coordinator of coordinators, recognizing that hospitals, health plans, etc. will continue with their own coordination efforts iii. Must have an attitude that embodies patient-centered focus and commitment to service excellence B. Agreement between patient and physician-led care team MUST: <ul style="list-style-type: none"> i. Provide clear expectations across the care team ii. Not be just another form combined with other paperwork iii. Be meaningful between patient and the practice iv. Create a bridge of mutual accountability

What is the best approach in developing my care plan to make it most meaningful for me?

Hosted by Phil Cass	A. Take as much time as necessary to develop a written plan (that is understandable) that the physician and patient both agree to – the basis for trust B. It is clear how to work the plan – clear responsibilities and accountability and the necessary education and supports identified to predict success for both parties
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These strategies will be incorporated into our plan as we advance patient-centered medical homes in central Ohio.

IV. CLOSING & NEXT STEPS

Biehl thanked everyone for participating and asked that what we need from health plans and self-insured employers to move from concept to practice is for them to submit **letters of intent** by 3/31/10 indicating the number (ceiling) of covered lives they intend to provide financial support for care coordination payments to recognized patient-centered medical homes selected by enrollees/employees.

Biehl asked those employers interested in learning more about involvement with the Central Ohio Patient-Centered Medical Home Project to fill out the supplied response form. They will be contacted after today’s discussion.

Access HealthColumbus will be holding information sessions on the Central Ohio Patient-Centered Medical Home project in early March for internal medicine and family practice providers who provide primary care to adults in Franklin County. The intent is to identify early adopters in our local primary care community.

In the meantime, a record of today’s discussion will be sent to everyone who attended.

Biehl thanked the organizations providing financial support for project administration: Columbus Medical Association Foundation, Employers Health Coalition of Ohio, Columbus Chamber and Health Action Council.

The meeting adjourned at 11 am.