

What do we think about this roadmap?

<p align="center">Make up, responsibilities and accountabilities of Coalition are key.</p> <ul style="list-style-type: none"> ▪ Coalition is a good idea – diversity, not to be influenced by a board, upfront ▪ Question about actual role of Coalition ▪ Who’s on Coalition? Role of Coalition? ▪ More involvement of all different interest groups in the room together for decisions if we implement major changes in health care delivery system ▪ Access HealthColumbus and the board of decision makers isolated from the process ▪ Coalition made up different skill level – grant writing, conceptualization, medical infrastructure, recourses – financial ▪ Do any coalition becomes responsible ▪ But Coalition is good but regular jobs are in crisis; allows themselves to step outside of them ▪ Make sure everyone (stakeholders) is represented on the coalition ▪ Would the Coalition have experience in this area ▪ Coalition: decide the size of this group, empower to act instead of just discuss – the accountability, ownership; time frame ▪ Coalition needs to include government, business, healthcare, consumers/advocates ▪ Coalition – broad base, cross sector participation and provider direction to the initiative 	<p align="center">Outcomes are key.</p> <ul style="list-style-type: none"> ▪ Measuring “significant improvements in health status”? may be too big – which indicators - - relative risks and risk adjustments in data utilization patterns, quality of life measurements may be more appropriate ▪ Measure negative outcomes that could increase the 3 year deadline ▪ You can get a couple of good surveys completed in the next 10 years which is good for evaluation ▪ Some measure of effectiveness can be: prevention, education, continuity of care – all hard to do but are good indicators ▪ How will benchmarks be determined? ▪ What other indicators to be concern of ▪ Clarity with identifying outcomes and being able to measure them – need to make sure this is done in a good way ▪ Outcomes – prevention – behavioral diabetes, obesity – health care is a lot more than treatment and diagnosis – it involves safety, housing, environment ▪ How set measurable outcomes ▪ Like the annual reporting of progress
<p align="center">Time frame is ambitious.</p> <ul style="list-style-type: none"> ▪ Three years is not long enough to see significant improvement – need short-term benchmark that indicate improvement; accepted assessment questions ▪ Attrition – low-income people tend to move frequently, 3 years too long ▪ Time frame is good ▪ Appears to be very ambitious – need to be broken down into smaller increments – 10,000 foot view ▪ 3 years is the minimal time needed to begin to measure outcomes ▪ Timeline seems rather ambitious ▪ Ambitious: but bringing comm. is NOT the easiest, hard to identify people to move things forward 	<p align="center">Need to define how funding will work.</p> <ul style="list-style-type: none"> ▪ Funding – payers agree to a different payment structure no just funding the current payment structure ▪ Funding – local sources cannot fund this alone – MH boards have started providing funds to pcp’s ▪ Who is going to pay for this? ▪ Resources – using what we have and trusting them – where are \$ coming from ▪ Need to include resources as well as funding responsibilities – identify where resources could be allocated and for leverage ▪ Reallocating resources

<p style="text-align: center;">Consultant's role is important.</p> <ul style="list-style-type: none"> ▪ Who will conduct the research? Collect data? Neutral, credible third party ▪ Hires a consultant who will then design model questions ▪ Is the consultant responsible for creating a new model, or tailoring a current model to Columbus? ▪ Consultant role is as project manager – knowledge of systemic issues & job is to get this initiative operational ▪ Do any consultants becomes responsible ▪ Where does the money comes from for Part B: consultants ▪ Is it just one consultant, competition process or local/national firm 	<p style="text-align: center;">Need definition of model.</p> <ul style="list-style-type: none"> ▪ Not sure we should commit to only one design/population – do 2 or more to compare; only one might fail and kill the entire project ▪ Specificity of 'medical home' would be helpful – is it prevention? Access to care? ▪ What is meant by "community"? ▪ Is there a philosophy our community can focus on, decided in advanced? ▪ Realistic, well thought out, like that it is starting with a pilot (segment of) ▪ Show me different options of pilots/medical home – it will become more real if there are specific models ▪ The term 'outpatient' must be used with the definition of medical home
<p style="text-align: center;">Learn from others to build models.</p> <ul style="list-style-type: none"> ▪ Look at other states ▪ Mountains Beyond Mountains – Paul Farmer – book – work done in Haiti ▪ Select a model (that is working in other community) and try in a small scale ▪ Other sites – learn from what has been done before - consultants who worked with other successful 	<p style="text-align: center;">Need to understand how pilot group will be selected.</p> <ul style="list-style-type: none"> ▪ Those with no primary care doctors show up at ERs ▪ How does model benefit 'un-insured'? ▪ Prioritize the group that will be tested in the system – uninsured, underinsured, Medicaid ▪ Pilot program – who will be in the group? ▪ Population to be served: ▪ Uninsured and underinsured ▪ Create a system comfortable to use for all populations
<p style="text-align: center;">Understand what we have and what we want.</p> <ul style="list-style-type: none"> ▪ If we shift reallocation changes from curative → preventive or sick care to well care ▪ HC is fragmented so people are motivated to do something about it ▪ Truly understands every day workings of the health care system. 	<p style="text-align: center;">Roles and support needed are important.</p> <ul style="list-style-type: none"> ▪ Support? Pharmaceutical companies ▪ Doctors' participation? Willing providers and consumers ▪ PCP needs to be paid to manage the care ▪ Access HealthColumbus oversee project! ▪ Like the roles of Access HealthColumbus will play ▪ Will employer involvement be leveraged? ▪ Identify and get the major players on board
<p style="text-align: center;">Questions</p> <ul style="list-style-type: none"> ▪ What will the demonstration look like? ▪ What is the starting year in chart to track to get this? ▪ Who will coordinate this? ▪ Relooking the design - are we committed to the design even if we are not meeting our goal the first year? ▪ How does all of the input from last community discussion – where does it fit in? ▪ Resource Phase – Criteria in choosing design? ▪ Are there legal barriers or liability issues to be considered? ▪ Is this roadmap including the CNHC centers and expanding that concept, or is this a new approach (Demonstration Phase)? ▪ How does patient education occur? 	<p style="text-align: center;">Other</p> <ul style="list-style-type: none"> ▪ Reallocate funds if – from local hospitals; effective use of existing resources – who will receive them ▪ Community care coordination is the key – position that was eliminated - Nurse is physician; office used to do follow-up – putting it back ▪ Pharm. – Try to give physicians the educational tools to educate the patient beyond just taking medication ▪ Cross section of comm. members ▪ Version of managed care with primary care physician emphasis ▪ Role of limited network ▪ Public, Medicaid programs, SCHIP, workers comp ▪ ER based programs ▪ Details, Details

**What are 1-2 most important thoughts that emerged in your conversation today
that you feel is important to share with others?**

<p align="center">Learn from Others</p> <ul style="list-style-type: none"> ▪ Define medical home ▪ Concreted examples are needed ▪ Are we re-inventing the wheel or use existing models? ▪ Learning from other who have already done such a project – barriers, success – then shape for Columbus ▪ Important to have an awareness that models have already been developed and piloted ▪ In case there is not an awareness, the Common Wealth Fund is expected to release a funding opportunity related to the Patient Centered Medical Home 	<p align="center">Make-Up & Responsibilities/Accountabilities of Coalition</p> <ul style="list-style-type: none"> ▪ Building Medical Home Coalition and who is on it is very important. Needs to have government official participating or engaged in activities, also need to involve key businesses – bring resources to the table (ex. AEP, Columbus Gas in every household, invest into community) ▪ Question is if the stockholders (coalition members) are willing to give up some of their missions/independents & control for the good of the community ▪ Accountability and make-up of the coalition with different skill sets, knowledge and abilities
<p align="center">Define Who Participates</p> <ul style="list-style-type: none"> ▪ Must include folks with primary care physician and those who don't & rely on ER and urgent care ▪ Who is target for this model? ▪ Define the population we are talking about – insured, uninsured, underinsured ▪ Define selected group of physicians/providers who will participate 	<p align="center">Determine Outcomes Measures</p> <ul style="list-style-type: none"> ▪ Three years may not be enough – need short term benchmarks that indicate “improvement”... - use existing accepted measures ▪ Study methodology: Designs/populations, participation/cooperation of payers, providers and patients; outcome measures (health indicators present relative risk issue, utilization patterns and quality of life measures may be more appropriate) ▪ Are these indicators sufficient to show if this is going to work?
<p align="center">Coordinate Care</p> <ul style="list-style-type: none"> ▪ Community care coordination is the key 	<p align="center">Consumer Buy-In</p> <ul style="list-style-type: none"> ▪ Which part of roadmap considered ‘buy-in’ from consumers?
<p align="center">Scope of Services</p> <ul style="list-style-type: none"> ▪ Make sure all areas of health are included (i.e. mental health) ▪ Make sure “lifestyle management” is included 	<p align="center">Just Do It</p> <ul style="list-style-type: none"> ▪ Move forward ▪ Community has talked of Medical Home for years. This is the tangible steps what it takes to do it ▪ Overall we can concur what is the detail that is going to make or break this

Café #2 What Ideas Do You Have for the Design of a Medical Home Demonstration Project

<p style="text-align: center;">How to determine the target population.</p> <ul style="list-style-type: none"> ▪ Who is eligible – what are the determinants ▪ Strategy to include the three main populations: <ul style="list-style-type: none"> ○ Employer plan covered individuals ○ Public coverage: Medicaid, SCHIP, workers comp ○ Uninsured and underinsured ▪ Underinsure and uninsured inclusive of everyone ▪ Different population of people in insurance status; medical home be a combination of both insured and underinsured ▪ Target Group – Cannot only focus on those with a primary care physician – must include those who use the ER/urgent care and not until they are sick, and pharmacies that have mini clinics ▪ Size of Demo Group – statistically valid ▪ In recruiting participants: <ul style="list-style-type: none"> ○ Starting with providers is maybe a good way to go, perhaps in one geographical area, with many health issues represented ○ Carefully consider: Who is participating, what results can mean for other Columbus residents ○ Maybe test 2 or 3 designs/populations and compare them? ▪ Works from the outside in: Seniors → ←Children Youth ▪ Target Group – includes un/under-insured ▪ All ages/lifecycle ▪ Have a control group ▪ Start with any of the 3 populations and work your way to the rest: <ul style="list-style-type: none"> ○ those uninsured and then expand to the rest or ○ those eligible for public insurance but not covered or ○ those already covered by insurance and work other populations in 	<p style="text-align: center;">How a Medical Home should look and be staffed.</p> <ul style="list-style-type: none"> ▪ Medical Home – Brick and mortar (comprehensive centers with eyes, teeth, mental health, physical medicine), non-traditional hours, cultural/linguistic friendly, quality, support to help folks who age/disabled and keep independent in their home, referral agreements, ancillary (transportation, prescriptions, medical interpreters, timely access) ▪ More available hours at clinics – open until 9pm perhaps ▪ Define minimum expectations of medical home: <ul style="list-style-type: none"> ○ Doctor available 24 hours ○ Referral to specialist ○ Access to prescriptions ○ Access to translators ▪ With physician becoming in a medical home becoming more patient centered and increase scheduling time, how would the physical be rewarded, for lack of a better word, if the physician experienced 3 no shows in a day. On appointments that could have been revenue generating appointments? ▪ Medical Home: Mental Health, patient education, prescriptions, Electronic/Technology expansion, medical for children ▪ Focus of the work is to develop the structure for coordination of each person's care in such a way that all existing health care players are engaged and collaborate to address the focus – not just treatment but must include keeping healthy, wellness ▪ Patient centered – connectivity ▪ More comprehensive, better quality care and primary care ▪ May need outreach medical workers to make sure patients return for follow up ▪ Create an environment that is non-threatening and pertinent to the specific population served ▪ Funnel referral sources to physicians ▪ Assign case manager/program coordinator of a multi-disciplinary team ▪ Figure out a way for people to pay for this – or the medical home concept will not work ▪ Think about cost differential on staffing (i.e. nurse practitioners vs. primary care physicians) ▪ Medical doctor
<p style="text-align: center;">Where it should be located and who should provide services.</p> <ul style="list-style-type: none"> ▪ One physical location where all the services are in so health consumers don't have to go place to place for services ▪ Use FQHC as a base model ▪ Does this involve recruiting MORE PCPs (ie. from OSU, OU, etc.) ▪ Expand community health centers, private doctors 	<p style="text-align: center;">How technology should be used.</p> <ul style="list-style-type: none"> ▪ Shared electronic medical records ▪ Centralize EMR, billings, care plan and they must be transparent to health consumers ▪ Appropriate data systems – EMR ▪ Use technology for creating efficiency in Virtual Medical Home ▪ Health Info Technology - Communication tool, sharing info, increasing efficiency

<ul style="list-style-type: none"> ▪ Expand FQHC's – good opportunity to bring in federal money and they already have an infrastructure ▪ Education to PCPs on what is a medical home – how is it different from their current practice? ▪ Implement project in inner city of Columbus vs. other areas of the city? ▪ 3 medical homes in a community? ▪ Clear strategy for selecting and enrolling physicians ▪ Pick 5 emergency rooms in the city and have a 'navigator' stationed in there to help people understand primary care and get a primary care doctor or help them apply for Medicaid so that they won't have to return to the ER ▪ How do we integrate the fragmented current systems – CNHCs, free clinics, private care, ethnic communities and evaluating real time capacity. 	<ul style="list-style-type: none"> ▪ Ensure electronic records part of design ▪ Data (PHI) must be shared across the system of care coordination – demonstration must include the development of the technology. Embed health care chart chip in participants arm ▪ Functionality of the medical home when patient moves to a new medical, how easy to transfer medical records ▪ Technological capabilities and accessibility determines the size of the medical network; start off small then build on each other ▪ Computer system – Electronic Health Records and Personal Health Records
<p style="text-align: center;">What types of services should be available.</p> <ul style="list-style-type: none"> ▪ More focus on prevention (early) ▪ Think about intervention (i.e. prevention classes) ▪ Broad but not too broad ▪ Patient: access to health care – Doctor, psychology, nutrition, eye, dental, pharmacy ▪ Integrated approach to health care (physical, mental, education) ▪ Need for basic standard services of care and need ▪ Need for 2-tiered systems? – Not to lower standards of current good care ▪ Should include x-ray, lab, etc. ▪ Tie into wellness centers (i.e. Integrative Health Care Center) ▪ Social determinants of health need to be included; not in priority listing ▪ Design that is built to respond to all the social determinants of health, that is cyclical, that encourages self-care enforced by the principals of smart growth (David Rusk – New Mexico) ▪ Connectivity: Care Coordination – specialty care, finances/employment, grocery store for healthy food, MD/office staff, primary care, hospital systems 	<p style="text-align: center;">How the demonstration should be evaluated.</p> <ul style="list-style-type: none"> ▪ Evaluated by separate entity ▪ Develop the outcomes by the individuals if is designed to serve ▪ Evaluation of WHY demonstration project worked/or not working ▪ In choosing outcome measure: <ul style="list-style-type: none"> • Maybe phases of evaluation • Be careful of measuring health outcomes for degenerative diseases – unlikely to show improvement in only 3 years ▪ Need to establish measurable ▪ Outcome based stipends (proven results) ▪ Reporting results to the community ▪ In analysis: <ul style="list-style-type: none"> • Stratify by SES groups • Stratify by practice type • Stratify by insurance/payment model

<p style="text-align: center;">How to build a culturally sensitive program.</p> <ul style="list-style-type: none"> ▪ Responsive to the cultural and experience of the communities ▪ Cultural competency – ethnic, socio-economic ▪ Outreach workers to represent their different communities (for each culture) ▪ Consider cultural backgrounds of population – some don't embrace technology ▪ Question: what does a different cultural want from health care? ▪ Cultural competent education and services ▪ Diversity in medical home, in various cross-population home ▪ Interpreter and translation services, not feasibly within the medical home 	<p style="text-align: center;">How funding should be addressed.</p> <ul style="list-style-type: none"> ▪ Fund through reallocation of funds (or by those who benefit i.e. insurance companies) ▪ Resources: Cost – Incentive to bring in doctors, insurance should not dictate what you do, reimbursement, pay 4 service, affordability, patient responsibility, compliance ▪ Budget and funding to start-up and implement and measure the viability ▪ Funding Partner (state employee benefit or retirement systems) ▪ Start with Medicare or Medicaid group, but don't stop there! ▪ Expand proposals that are already in place – Section 125
<p style="text-align: center;">How incentives should be developed.</p> <ul style="list-style-type: none"> ▪ P4P incentives ▪ Incentives 1) current payment system is inadequate; p4p needs 2 phases 2) Pay incentive for improved outcomes (performance outcomes of a medical home as a whole, not measured at the individual practitioners) ▪ Incentivize medical students, nurse practitioners to “buy in” to this model – No FP or PCP level commitments ▪ Ideas: Doctors unwilling → incentive system, ease to access to medical records (Electronic chartings), nurture to encourage responsibility to patient health, social services, patient education, scheduling, doctors becoming more patient centered Focus not on increasing doctors' salary but allow those practices who want to be medical homes have the finances to do so 	<p style="text-align: center;">What partnerships/involvement are needed.</p> <ul style="list-style-type: none"> ▪ Full engagement of the Coalition stakeholders ▪ Bring health consumers in to design the demonstrating project ▪ Role for caregivers? Training ▪ Consumers involved in design (voice in how project works) ▪ Bring College of Medicine to the table! Keep students local after education; attract to PCP Task Force together to include students/practitioners ▪ Involve physicians in design process ▪ Role for volunteers? Training ▪ Utilize existing capacity of public insurance: Molina, CareSource, etc. Use them in Coalition or any other way ▪ Members of the Coalition need to demonstrate how they provide community benefit by being part of it
<p style="text-align: center;">What barriers need to be addressed.</p> <ul style="list-style-type: none"> ▪ Need for removing barriers to access due to money, lack of transportation, time off from work ▪ Transportation issues ▪ Identify and address BARRIERS/evaluate how barriers affected outcomes (i.e.do medical homes that do more effective work in addressing barriers affect final outcomes) 	<p style="text-align: center;">What types of education are needed.</p> <ul style="list-style-type: none"> ▪ Teach health consumers preventative self-care skills ▪ Figure out education/health literacy for the users ▪ Patient education ▪ Educational/marketing piece for consumers ▪ Question: How do we teach or empower members to utilize the system created?
<p style="text-align: center;">Learn from others.</p> <ul style="list-style-type: none"> ▪ Initiatives in Montgomery City, MD and Portland, Oregon are examples ▪ Does anyone have a working, succeeding pilot? ▪ Models already exist 	<p style="text-align: center;">Other comments.</p> <ul style="list-style-type: none"> ▪ Member ↔ cultural brokers ↔ provider ▪ Provider Task Force – 14 Drug Formulary - Pharm. Carve Outs ▪ Approach the consultant plan – used to gain input from ALL in the design option for the demonstration ▪ Consider change/simplifying the 'medical home' term – may be too confusing for general public ▪ Plus communication to all stakeholders

Advice

<p style="text-align: center;">Words of Wisdom</p> <ul style="list-style-type: none"> ▪ Keep your eyes on the prize – an equitable system, with necessary regulation ▪ Be realistic ▪ Keep it simple ▪ Be cost effective – ensure best use of each \$ \$ ▪ But don't rely on pre-conceived notions (be open minded) ▪ Work on sustainable communities model - doctors close to patients ▪ Small scale success is better than grandiose idea that will never become a reality or fails ▪ Make it happen sooner than later. This community needs action now! 	<p style="text-align: center;">Make Up of Coalition</p> <ul style="list-style-type: none"> ▪ Wider coalition with all interest groups represented, with an equal voice (city, county, COTA, physicians, nurses, PASs, APNs) consumers, employers and task forces of providers and medical/insurance students to figure out how to incentivize providers to remain at work in the network. ▪ Who the members of the Coalition is critical... Must be representative of community ▪ Let the participants vote on specific actions – These can be guidelines for you, not actual specific actions ▪ Let people vote on ideas
<p style="text-align: center;">Communication</p> <ul style="list-style-type: none"> ▪ Use a smart board – ask questions, survey the participants and share responses in a more interactive fashion. ▪ Survey – ask questions where one question builds upon the other (you did this) ▪ Need to let the community be aware of services available. Get out, knock on doors – talk to folks on the street, inform neighborhood papers and schools ▪ Continue, throughout the 3 years, this open process of meeting, working together and documenting progress ▪ Should handle the communication to the community and not depend upon a new coalition to do it 	<p style="text-align: center;">Partnerships/Buy-In</p> <ul style="list-style-type: none"> ▪ Partner with all needed stakeholders – providers, payors, families, etc. ▪ Need key business, government, foundation, insurer, stockholder at the table – can you get them there? ▪ Involve people in the design of project who will ultimately participate ▪ Need to put your efforts on getting community and stake holder buy-in to the demonstration ▪ Need to consider how to develop commitments on part of those operating the medical home services to continue the demonstration
<p style="text-align: center;">Learn From Others</p> <ul style="list-style-type: none"> ▪ Don't recreate the wheel – make use of existing models, infrastructures and resources ▪ Don't reinvent the wheel, there are foundations offering grants (RWJ, Commonwealth Fund) supporting this ▪ Be inclusive and build on current efforts rather than re-inventing the wheel. Use current resources in community ▪ Take advantage of working models 	<p style="text-align: center;">Accountability</p> <ul style="list-style-type: none"> ▪ Engagement and ownership is critical ▪ Establish clear line of accountability, particularly as Access and its board is ceding that to the Coalition
<p style="text-align: center;">Use of Consultants</p> <ul style="list-style-type: none"> ▪ Our most important piece of advice is to be sure the consultant serves not only as a consultation but also as a project manager, too. 	<p style="text-align: center;">Other</p> <ul style="list-style-type: none"> ▪ I am willing and able to give more time to this project. I have a disability advocacy/public policy background

Participants

Jacquetta Al-Mubaslat
Douglas Anderson
Pam Argus
Catherine Anne Bare
Kerry Beckwith
Jeff Biehl
Lea Blackburn
Roy Bobbitt
Alvin Brea
Dana Charlton
Michelle Cunningham
Judy D'Andrea
Mari Dannhauer
Allard Dembe, PhD
Wanda Dillard
Wendy Dillingham
Harvey Doremus
Jody Dzurainin
Lisa Fallara
Margaret Frindell
Lorraine Furtado
Jewell K. Garrison
Rosalie Goins
Jeanne C. Grothaus
Maureen Hall
Tim Hawthorne
Isi Ikharebha
Stephanie Jursek
Francie Kaufman

Kim Keinath
Judy Kress
Travis Menke
Michael Mishkind, MD
Michelle S. Morgan
Laura Moskow Sigal
Maggie Neely
Abbie Obenour
Karen O'Brien
Noreen Palmer
Cathy Phillips
Jason Pierce
Malcolm J. Porter
Ellen Rapkin
Maria Rodgers
Emily Savors
Thomas Scheid
Alicia D. Smith
Sandra Solano-McGuire
Scott Solsman
Ying Studebaker, RN, CNS, CTTS
Tusdy Toneletti
Diane Warren
Beth Whitted
Carla Jean Williams
Wendy Winger
Donna Woods
Cy Zibrik