

**AMCHP Annual Conference, 2010**

**Moving Ahead Together:**

**Celebrating the Legacy, Shaping the Future of Maternal and Child Health  
State Partnerships to Improve the Quality and Availability of Medical Homes  
to Vulnerable Participants**

March 6-10, 2010

MICHELLE: The Academy of Pediatrics worked closely with the \*\*\*\* staff to coordinate this session and we worked collaboratively on selecting faculty who we thought would be able to bring you information about the partnerships and the models that are going on in their respective states related to Medical Home and vulnerable participants.

So I will introduce each person as they come up, just as a matter of logistics, each speaker will talk for about 15 minutes, and we'll save questions for the end, unless you have some absolute burning desire to ask a question of a speaker right after their presentation. So I'll go ahead and introduce Dr. Kraft first.

So Dr. Kraft is a member of the Academy of Pediatrics and actually is very active in the Academy of Pediatrics on our Medical Home activities and also our community pediatrics activities. She's a primary care pediatrician, but she also wears a lot of different hats and she teaches residents, she's on faculty at Virginia Tech Carilion School of Medicine in Roanoke, Virginia. She's been very, very involved in some of the learning collaboratives related Medical Home that have been going on in Virginia in the

past and one that's currently going on right now. So I think she's a great kick-off speaker for this presentation and I think I'll just turn it over to you right now.

COLLEEN KRAFT: Thank you, Michelle. After our talk on healthcare reform and health reform, it's really very interesting to bring in an example of what really is going on at the grass roots level within states to be able to really make this happen. So we're just going to talk a little bit about our goal, which is that every child deserves a Medical Home and that every child has a Medical Home. And what is a Medical Home? It's something that we all know what that is when we see it, but to really define it to people takes a bit of explanation and even though it really started within pediatrics, we still have to explain that it's a place that combines people and process and place. It's that central place where primary care is coordinated, your headquarters for care, it's the team of people that are delivering care. And that we have our principals, that it's accessible, that it's community based, family centered, comprehensive, compassionate, culturally effective, coordinated care.

And why it's so important to keep talking about this with our pediatric values is that the good thing that's happened is that our adult colleagues have joined forces and said, "Medical Home is a really good thing to be doing." And one of the unintended consequences is that Medical Home for the adults looks like this, NCQA, patients that are Medical Home, and look at this, these are good things, they're processes, it's test tracking and referral tracking, and care management, and patient self-management

support. And here I am thinking as a pediatrician, what happened to compassionate and accessible and coordinated?

So Medical Home as it is talked about in the general framework with the adults is about process. You know, Medical Home with kids is still very much about value and how we bring those two together as we're really defining our Medical Home. Because the reality is, is that this is what payers are looking at. This is what, you know, we actually had our pediatric council meeting with Anthem Wellpoint, and they said that you can either be in our pay for performance, or you need to be externally accredited by PCMH and CQA Level 3 for any kind of access to payments.

So what we came together on, our joint principals, is that there's a personal physician involved, there's a physician directed medical practice, whole person orientation, the care is coordinated, integrated, quality and safety, which we really hadn't talked about anywhere before, our hallmarks of the Medical Home, that there's enhanced access to care and then payment at appropriately recognizes the value.

And the way you do that is by working together. It's by integrating your health system, it's bringing public health and community principals into your hospitals and healthcare foundations. Working to better to collaborate your primary care and specialist to have a coordinated system.

And that's exactly what the problem is with child health right now, is that we've got a fragmented system delivery, not just with healthcare but how do we roll in home visiting and behavioral health and our Title V programs. And all of these things are fragmented, their funding comes from different places, and when we hear about cuts, you know, we worry about one end and balancing the other, but it's really, how do we better work together, which is most important.

And we know that this is really important because of the decline that we've seen because of working together in acute problems, but the rise that we're seeing in things like childhood obesity, I love this slide, but this is really very, you know, typical of what you're beginning to see out there now, what is the norm for kids. You know, asthma, prematurity and infant mortality, our kids with complex special healthcare needs, and the increase in our kids with behavioral health disorders and autism.

And what we know also is that when we're looking at life health course development, what we know is that it's those early experiences that help to solidify a family and help with early brain development and that we know that families that who endure poverty, families who have decreased health services, families where there's discord, families where there are stresses, those are the things that bring those at-risk kids down into that delayed trajectory.

We also know if we want a healthy trajectory, there are things that work. We know that parent education works, we know that emotional literacy works, we know that reading to

kids works, we know that appropriate discipline works, we know that health services, we know that preschool works.

So here's my question, which one of these are being cut in your state budget this year? Every one of them. I mean, every one of them there. So the response that we've been trained to do as professionals coming from different areas is well, we're not going to be able to serve that many kids or we're going to have to cut back on staff. And you know, how we reframe this on how we better work together and be creative and understand that creativity is born of limited resources, it's sometimes is an opportunity for us because if we think about how we target things, you know, our programs by and large will take kids that may be in that group who are disabled and move some of them across the board. It's really looking at that universal curve shift. You know, how do we bring this to the norm and help everybody move ahead?

So what we did in Virginia, was we actually developed our partnership between the Virginia Chapter of the American Academy of Pediatrics, our Virginia Department of Medical Assistant Services, Medicaid agency, our Virginia Community Health Centers, and then the Carilion Clinic, where I'm currently working. And what we did was we applied as a group to the National Academy for State Health Policy Project on building medical homes and state Medicaid AMCHP programs.

And we were one of the eight states selected, the leadership session was in October of 2009. I did not attend because it happened at the same time as our national meeting, so

I wasn't able to do that, but several of our folks from our Medicaid Department did go there and what we decided to do is define our project scope. Define and recognize medical homes and understand that Medical Home is not just NCQA, but there's some other values, some other important things that we need from Medical Homes.

Exploring supports for practice change, supporting supports for payment policies that we should change, and then measure progress, what are going to be some of our outcome measures. How are we going to improve access, improve quality, and keep the costs down? Which is the whole health reform argument. So our Medicaid group was our project lead and they convened with the rest of the partners to collect what would be our outcomes for this project in terms of access quality and costs of care.

Our focus was on the southwestern part of Virginia, which has limited access to care, they're very underserved communities, there is no Medicaid managed care presence in the far southwest of Virginia, and there were two very different health systems that we could take a look at how they approach access quality and cost of care. So our Virginia Community Health Centers were one of the groups and there are several of them that are located within southwestern Virginia, and the two things that the groups have in common is that both groups, individually, on their own, had decided to really tackle quality issues within their organization. So this group, which has federally qualified health center, or enhanced Medicaid funding, decided to invest in electronic health record, and they have ongoing quality improvement and disease management programs within their organization.

So that was one group that we looked at, how could that improve access because they take Medicaid and uninsured, how could it improve quality, because they're actually doing the quality programs, and they have an electronic health record, and what will that do with the cost?

The other group that we decided to work with was within our Virginia chapter, and we partnered with our state Title V group on the Virginia Systems Improvement Plan and part of that plan is developing a statewide quality improvement project on developmental screening in the medical home and we developed more partnerships with families. This is kind of a busy slide, showing you who all is involved, but the idea was, was this, is that if we could work within our physician community, our pediatrician community, on how do you implement developmental screening in your practice and then once you define those kids, how do you connect them to the early intervention services or to home visiting services, or to the places where they're going to go get the help and how do you implement and have ongoing communication with these groups? Because that's how you develop what I've entitled the Medical Village. This is a project that we're doing within Carilion, is that medical care is just a tiny slice of that child's life. It's where they are in school, where they are in the community? Who helps them out in their day-to-day lives, who supports their parents? That really is the biggest part of their learning and their development and their health.

At the Carilion Clinic, we have Medical Home pilots in our family medicine and pediatrics practices and interestingly, the Carilion Clinic decided when they wanted to implement Medical Home, they were going to implement NCQA, patients that are Medical Home, and start with our family medicine practices. And that makes sense to all of us who know about funding and finances, because who's expensive in the healthcare system? It's adults with chronic care conditions. So Medical Home, through NCQA, was implemented with our family medicine group. We actually had the first practice that achieved the level 3 NCQA patients that are Medical Home, in the State of Virginia, and we're working with them and learning with them on how we can bring that down into pediatrics.

The idea of an accountable care organization funding model, and I'll talk about that in just a minute, and then what we are doing with our ACO and working with the \*\*\*\* Institute on looking at data and figuring out, again, how do we get enhanced access, improved quality, lower cost?

So an accountable care organization is a financing model where an inpatient and outpatient group together, decide that there's going to be local accountability for cost, quality, and capacity. And the idea is that if everybody is accountable for what they order on a patient, what they spend on a patient, where they manage a patient, then there's going to be shared savings that could be put back into the system to better improve your care. And then along with that is performance improvement and performance measurement, because like I say to my physician associates, who here

does not provide quality care to their patients? You know, nobody is there. And you say, how do you know that you're providing quality care?

Quality and the idea that quality is something that's based on measurement is a very new concept to doctors, but it's getting there and it's one of the things at Carilion that we found important.

And the idea that an accountable care organization can take a pool of funds and develop, first of all, a meaningful HIT program, we have a program now, and I'll give you just a real quick example, a patient that I saw yesterday, I saw an eight year old in my practice who has what sounds like, or new onset absence seizures. And I talked with his mom about that, and we basically needed to get him to an EEG and then get him in with a neurologist. And so I talked with my care coordinator, put the referral into the electronic health record system, and my care coordinator made those appointments right away, I heard back from mom later that day on my way up to this meeting that she's scheduled for Thursday morning, for a sleep-deprived EEG, and that she has an appointment with one of our neurologists early next week. And I told her what I would do is see if, if we have an abnormal EEG, see if I can get her in sooner. So at my electronic health record, I can see when mom is scheduled, I can see if and when she shows up at the EEG to get her appointment. I had sent a note to the neurologist, copying my note saying, this is what's going on with this child, the EEG is going to be first thing Thursday morning and I've already heard back from him saying, "I will be checking on that for you."

Now, this is all happened, this patient I saw at 10:00 yesterday morning, and it's 3:00 this afternoon and we already have that level of care coordination. That's meaningful HIT. And to be able to invest in that system and promote that system is really important.

One of the things that we've done is we've actually hired care coordinators in the adult medicine realm. We joke about this, Kim Robertson, our nurse manager and I, that pediatrics is going to have a bake sale or do some other things, but we actually have care coordinators that we're now working within our system to develop what they're doing. But the idea is that if the inpatient and outpatient organization as a whole decides that they're going to make a difference, they can save a lot in terms of their funding.

What's been some of the downside, well, medicine, as we know it, not with our population, but with our surgical population, radiologic population, people who are paid by procedure, that's where the big time health dollars are going and so what Carilion did was sat down with the radiology department and said, "Your contract is going to be based on a base salary, quality metrics for the first tier bonus, production for the second tier bonus." And everybody but one person out of our radiology department quit.

So, what you have to do is you have to bring along people who really understand that the way we've been practicing medicine is not going to be the way we can continue to practice medicine, and that all really is part of the cost.

So we're going through some of our, you know, turning ourselves on our heads with that process as well, but what's great is that there now is a different type of way that an organization is able to keep costs down, but improve quality and we have open panels to our Medicaid patients, we don't turn anybody away, which is wonderful.

So the next steps are really going to be measuring this access quality and cost. In the community health center model, where again, it is all Medicaid or uninsured and they had the enhanced federally qualified health center payment, or the Carilion Clinic, which is an accountable care organization model, where we share some of our savings and put that back into the system to increase the quality of care.

The learning collaborative is going to be happening, we're already recruiting for practices within Virginia and the question is, will a better connection with our community care partners increase access and quality? One of the things that we know already is when you have a home visiting system within your practice and you know that you've got kids who are going to make it to your appointments, they're going to be followed up with their care, you have practices who are more likely to see more Medicaid kids. We know that's something that happens in our system.

And then to see, what are the emerging models that encourage Medical Home? Is that model for care for all vulnerable individuals?

So that will be here to come within our project and thank you very much.

MICHELLE: Thank you, I didn't even have to use my two-minute warning sign. So our next speaker, while I switch the slides over here, is from Minnesota and boy, has there been a lot going on in Minnesota lately! I'm excited to hear the next talk.

Now, this is a PDF, was there a Power Point? Okay.

So it's my pleasure to introduce my next speaker, her name is Marie Mayas-Vorres, I hope I'm pronouncing that correctly. And again, as I mentioned, Maria is from the State of Minnesota. She works in the Department of Health in Minnesota and she's been in the department there since 2008 and she's really responsible for a lot of the program implementation that goes along with our home care, Homes Legislation, which is what I think a lot of us have been hearing about if we walk in the Medicaid and Medical Home circle, so this is a joint project between the public and the private sectors, and she's been intimately involved with that. And she has been involved in working with this multidisciplinary team and working on a care model in family medicine and also Marie has extensive experience with implementation of the Epic electronic health record. So she is going to tell us a lot about what's going on there, and let's see how this works for you and then we'll hopefully be able to get—

MARIA MAYAS-VORRES: Good afternoon everybody. Can you all hear me okay? Well, it's really my pleasure to be here. This is my first opportunity to participate in any real Title V activities and in AMCHP and what a wonderful conference it's been.

In Minnesota, we have a new comprehensive state health reform package and we truly have a new physician around a better state of health. And we actually have four components to our health reform, our statewide health reform package, and that includes focus on population health, market transparency, and enhance information. We have a new statewide quality reporting system, where all clinics need to report based on agreed-upon measures.

Care redesign and payment reform and actually we're going to talk a little bit more about the clinical redesign portion for Healthcare Homes. And then some new consumer engagement programs.

So it's kind of a package and we're looking at each of the elements as building our foundation as we move forward to a better state of health.

Now, what I wanted to do today in talking about Minnesota and the Healthcare Home, is, to start a little bit at the beginning because one of the things that I think is really helpful when we go to conferences like this, to hear about what are the lessons that we really learned and how we went about doing the work, not just what we did, but how did we go about that, because that's the really hard part.

So we're going to just start with the fact that in our state, we had tremendous leadership through our Title V programs and through our Minnesota Children with Special Needs

Programs, and our Department of Human Services. And what they really did was they embraced this definition related to continuous comprehensive and family-centered coordinated compassionate care, and I think that was really the first step, was to really embrace the components of the position paper.

And part of that was really making a decision very early on, many years ago, that patient and family-centered care is one of our core principals and we have lived that in every single step of the way by having patients participate in every workgroup, every committee, every learning collaborative session, and in the design and the development and in fact, they were instrumental in supporting and getting our legislation for our state.

So our development of partnerships with Patients and Families has been very key, and I was just at the IHI conference the last few days, and went to a number of sessions where including Patients and Families in really the work of moving forward is really brand new for lots and lots of groups.

So the other thing that we really felt very strongly about in our development and also was well-supported by the position paper, is the need to develop extensive community partnerships. And so, we as we move forward, we really develop partnerships with early on, the American Academy of Pediatrics, the Minnesota Medical Association, \*\*\*\* Minnesota Community Measurement, and a number of groups in Minnesota that really lended to the partnerships and really believed in the Medical Home consensus statement and I know I probably haven't mentioned some of them, but all the other

professional academies and measurement groups were also very actively involved, as well as our academic centers, such as the University of Minnesota.

So we really believed that working together, we were able to develop this public-private partnership and we actually started at the very beginning with a few of those activities that were happening within Title V and we really had some very important lessons that we learned at the very beginning. And the very first one in 1995 was our first real effort at starting to educate primary care providers that we needed to function and work in a different way, and there was a new concept coming and so learning, learning, learning was really the thing that we learned in 1995.

In 1996, we really looked at, well, you know, what we really need to have is the universal benefit set and our leaders and mission really took that on and one of the things we learned at that point was that that was really too big of a leap. Setting a universal benefit set with lots of new things in it, like care coordination and things that we'd talk about typically about the Medical Home, was just a very big leap. And also it was a very top down kind of program development and what we really found is that bottom up really makes a significant difference.

And the last thing that we learned along our journey really was related to the National Medical Conference in Hawaii, the Promise to the State, where we really promised that every child would receive seamless healthcare, and that's a promise that we talk about and that we believe that we're living as we move forward in the development of the

patient-centered medical home and especially in extending that promise to other groups such as adults with chronic and complex conditions.

So we had to start this process of building trust and it's something that we're very proud of in Minnesota as we've been developing the Medical Home or the Healthcare Home, and we'll talk more about that in a minute, in that while we don't always agree, we always commit to coming to the table and we have brought some of the most energetic workgroups together around really discussing and hashing out so that early engagement and participation has been really part of our philosophy at the beginning and also, bringing the people who are receiving care and providing care right to the table. So not just administrators and policy makers, but physicians and nurses and patients and quality people right to the table. And so often, we found that it isn't the people who really are doing the work that are part of the solution and so that early engagement is really difficult.

The next part of our history is really about one of the things that we're very, very proud of and that's our learning collaborative that we developed from 2002 through 2009, and it was coordinated by the Minnesota Special Needs Children's Department at the Minnesota Department of Health, along with the American Academy of Pediatrics and we did a learning collaborative implementing the concepts of the patient-centered medical home over five years, and we've learned some very important lessons.

First of all, it was our first opportunity to work with the IHI breakthrough series, and we found that by working together in a learning collaborative environment, that clinics really learned from each other, and that we were really able to engage, especially physicians. They were learning from each other, they were sharing with each other, and they were finding real things that really worked. And we used a lot of the IHI breakthrough change package philosophy and a lot of their sharing and engagement principals. So the learning collaborative itself really became the foundation. We learned how to do PSA cycles, how to do small steps in change, how to measure, measure, measure, and that was something new and often not readily understandable or apparent right in the clinic when you're trying to implement first order change.

So we learned a lot of things in our learning collaborative, we met and exceeded our expectations around meeting our Title V six core goals and it laid the foundation for our 2008 legislation, which I'm going to speak about, and also our 2007 legislation, which I'm going to speak about.

Our Patients and Families that participated in our Medical Home learning collaborative were really very instrumental at the state legislature and if you ever have an opportunity to implement legislation to support the work that you're going to try to achieve, I would say make those patients and families, have them be your true partners because they really led the way, they were very convincing and instrumental in telling our legislators what it really meant to have a patient-centered Medical Home in their practice and along with their doctors.

So in 2007, in Minnesota we implemented what's called the PCC program, and Primary Care Collaboration and that program was for care coordination in those sickest fee for service Medicaid patients. Now, that program has been implemented as of last summer, and as of right now, we have roughly 25 clinics in Minnesota with over 500 patients, including children with special health needs, and families and others with those chronic conditions. Over 500 patients are currently enrolled and again, we partnered related to our care coordination development of those standards.

In 2008, our landmark legislation was enacted and that's where we really coined a new term called a, I guess I got a little ahead here, called a Healthcare Home. At this point we learned that while the patient-center Medical Home had all the core principals that we wanted to embody, we needed a broader community perspective and that we were really focusing on health and not just healthcare. And so we implemented a new definition around the Healthcare Home. And while not everybody agreed to how we were moving forward, everybody did agree to commit and partner in the development of a new framework and at that point, we developed a new mission, we added additional partners from a number of organizations across our entire state, and we decided it was time to adopt a new framework and we utilized the triple aim with the goal of really starting with the end in mind and improving population health, patient consumer experience, and improving affordability of care.

We brought together around 200 people that participated from all different advocacy groups, patients, families, different primary care providers, nurses, nurse practitioners, physician assistants, and lots of other groups to formulate what are now the five basic standards related to our Healthcare Home.

Now, all of these standards are standards that you've seen in the NCQA and other patient and family centered Medical Home, so what I want to do is just tell you what's a little bit different. The first thing related to the Healthcare Home in Minnesota, is it is far less technical oriented than perhaps the NCQA might be and a clinic would not necessarily have to start with having an electronic health record implemented. Although we do require a registry, and we require that to be searchable, a searchable electronic registry, we felt that although we totally endorse the electronic health record, we don't want to limit any practice in our state from going ahead and getting started.

The next part of it, is that it's very patient and family centered driven, it's values driven, and we based a lot of our work on shared decision making. And when we actually wrote our legislation, our rules, for certification as clinics become certified in Minnesota, our rule writers were, well, now, how are we going to measure values? How are we going to measure patient and family centered care and what do words like trust and belief, how do they fit into a law? So it was really quite a big challenge for us.

The last part of it, around care coordination, is that we really require the functions of care coordination. We learned a lot in our Medical Home learning collaborative about

having a single responsible person that can really help coordinate communication. And the last part of what's different for us is not only do we believe in patient and family centered care, but we require it in our certification standards and patients and families are required to participate in the learning collaborative, and they're also, the clinic is also required to have patients on their quality team.

Now, what does it mean to become a certified Healthcare Home in Minnesota? Well, the first thing is that that means is that clinics are, once they become certified as the Healthcare Home, the state will go out and do a certification process, the site visit, go out and see how the clinic is doing their work, and it means that they're really entitled to a new payment mechanism, a per-person care coordination payment that's risk adjusted, based on the clinical severity of the patient.

And I'm not going to get into all those details around the payment methodology today, but I would direct you to our Minnesota Department of Health, health reform website, where all of our standards and criteria, our certification tools, and also our payment methodology and our learning collaborative research and reports are out there for more of those details.

So I just want to spend just a couple of minutes just sort of summarizing what we really learned. So the first thing we really learned all the way through this journey of the last ten years, in getting to where we're at today, which is really statewide implementation. Right now, today, we have over 25 organizations that have already submitted their

application for certification from every corner of our state, rural, urban, FQHC's, and they're really moving forward and embracing our standards and criteria.

So doing visioning and setting the plan with partners and including a wide variety of community, patients, clinicians, payers, and Medicaid, really I think was the foundation to our success and we dreamed big. At the very beginning, we had to narrow that back down and do it in a little bit smaller chunks, but we dream big and long term.

The next thing is to utilize existing programs. Without those early Title V grants and without the early dollars, we wouldn't have been able to build the kind of foundation we have, and I think we have to find ways to take existing programs, because as we heard this morning, there isn't going to be any really new money. So we have to take existing programs and we have to figure out how to get there through those existing programs and build transparency and earn engagement and support.

I cannot tell you how many people that have come to us and said, we couldn't believe that government would be so transparent and listen and really engage us in coming to the table. And I believe that that is truly the cornerstone to our success. And people were willing to give their time, we didn't pay anybody, except for occasionally we paid some stipends for travel for patients and families. And organizations gave their expertise freely and there was great engagement and sharing.

The other thing is, is we needed to make sure over and over that our legislators knew what we were doing and so we really engaged our legislators, we had a real plan about making sure that our legislators were involved and that they felt that they were participating, as well as our community. And we early on also identified the challenges, and we really strategized, so we said, what do we have to have to implement a statewide, effective Healthcare Home? We had to have a payment methodology, it's been really hard, but we're in implementation. We had to do measurement and we needed to measure outcomes and we're working like crazy on that. It's been really hard, but we identified that that would be challenging.

And we knew that there would be some clinics that would be concerned about having to participate in a certification process, and while I do believe sometimes there's grumbling about why do I have to show somebody that I'm implementing a Healthcare Home in order to get paid, they're on board and they're applying.

I think I've already spoke to bring patients and families along the way. So truly by bringing all of those different expertise together, I think we have a better product.

The last thing is, is that I always think that we're missing one important point in the triple aim, I would have called it the quadruple aim, in that I really think we need to focus on satisfaction for our clinical teams. And while we're implementing this new team working environment, it's really hard work and we found that having a learning collaborative

structure in place, where's a place to support teams and to share learning was a very effective way to make this kind of change.

Learned from communities, state, and federal partners, so it's try, try, try at home, but learn nationally, I think we hear that over and over again, we believe that. And, you know, John Hurley said, "Small is beautiful, cut it in half, cut it in half, and cut it in half again." Baby steps, PDSA cycles, celebrations of small steps of change.

So we believe that as a state, we've been able to come together and say we're going to do Healthcare Homes based on population measurement with accountability. So as a Healthcare Home becomes certified this year, they need to become recertified next year. The standards are implemented over two years and by the end of year three, its outcomes measurements that will continue to determine based on an established set of benchmarks, whether a clinic remain certified.

So somebody said to me, "Oh, gosh, you implemented a certification program with teeth, we actually have to improve to stay certified." So we're figuring that out at this point on how to do that.

The other thing that we are doing along the way in the line of utilizing existing resources is that we have worked with the leadership of our mission program and our mission nurses that are out in the community across our five regions in our state are actually actively working with clinics around Medical Home, or Healthcare Home

implementation, and also sort of bringing together people from the community and clinics. There seems to be sort of this chasm between public health and local public health and clinics and it's a hard bridge to cross. And so our mission nurses have really just got, have just gotten started in how to bring groups together our there around the state, bringing the issues that clinics and communities are facing as they implement Medical Homes or Healthcare Homes back to St. Paul so that we can work with them to strategize on implementation and capacity-building initiatives. So that has been a really positive thing.

And I think the last thing that we've had to do is to double check all the way along the way that we were really implementing what we want to implement. And I think that's part of why we decided not to just go with the NCQA, but to go through an engagement process of what do we in Minnesota believe is best for us and develop standards that we could engage in and that we believed in. So if you think that you're implementing Medical Home or Healthcare Home, double check that over and over and over again, because we often deal with the, "Well, aren't we doing that already?" And so, some of it is really about pointing out what are the differences and helping people to really understand that it's almost a belief and a feeling, as much as it is concrete steps.

So we truly have a vision in Minnesota and we're really working on transformation. And as I sat at the table over all those months of workgroup meetings and heard the facilitators say, "Now, do you believe that standard is really transformational and how will you measure that and how will the community engage?" And so we asked those

tough questions and so we're really looking for a state of change. We're really looking for culture change, we're really looking for primary care, which is the backbone of our delivery system in Minnesota, to really create a new patient and family-centered, team-based environment.

I really think by focusing on the triple aim, having certification in measurement, and having a new payment methodology, that we have the right recipe in Minnesota to move forward.

Just so you know, as of this date, we have over, right around 25 to 30 clinics that have, clinic systems, or individual clinics, because you can apply for certification in a number of ways, have applied for certification. We will certify our first clinic in April and we will start paying for care coordination payments in July. So hopefully we'll be back next year to tell you how we did. Thank you.

MICHELLE: Thank you so much, wow. I have a lot of questions that could take up the rest of the time.

It's really my pleasure to introduce the next speaker this morning. Our next state that we're going to focus on is Colorado and Gina Robinson is here this afternoon to talk to us about what they're doing there. Gina has been involved in this game for a long time, over 20 years, or almost 20 years, where she's been a real leader in her state and nationally on policy work and program work related to promoting access for kids and

families and especially focused on vulnerable and underserved populations and children.

So Gina is currently an administrator with the EPSDT program in Colorado and she does a lot of administrative work on case management work through the Department of Health, and she's in the healthcare policy and financing branch of that agency. Her position really involves a lot of compliance issues with federal and state requirements and regulations and she works very much with a lot of different other agency staff and other program staff in her state, as well as many of the providers throughout the State of Colorado. She oversees the development and implementation of the training curriculum for both EPSDT, outreach coordinators, and providers.

So, Gina, thank you for coming.

GINA: Makes it sound kind of scary.

MICHELLE: It sounds interesting.

GINA: Just wanted to give you a slight overview of Colorado, while I start talking. I do have to say ditto and ditto, being last has its advantages and its disadvantages in a way. I'd love to just be able to say ditto and sit down, but Colorado also went through those same learning collaboratives and kind of headed off in a different direction, so we'll kind of talk about that.

As you can see, we have about 70,000 births in Colorado each year and about 49, 5,000 kids in Part C, and we estimate that 17.6 of all children ages 1 to 14 have some type of special healthcare need. We do use that broad definition of anybody who uses services above and beyond a normal child fits in that, so I think that's why that's a little bit higher than normal.

We also wanted to focus on quality healthcare again. I know you've heard all this, we have the same family-centered, culturally-component, coordinated, ditto, ditto, not going to read them all again, although trying to remember them is like trying to remember the Seven Dwarfs, don't forget that. And we again, started all the way back with that NCQA, or that \*\*\*\* learning collaborative in 2001. We took that to heart and we really took it back to Colorado in several ways. We were required as a part of that \*\*\*\* learning collaborative to have physicians, to have care coordinators or case managers, and to have parents on our team, or we couldn't participate. So we have had all of those in place since the very beginning, because it was always expected. And part of, when I go and speak nationally, people always say, "Well, how did you do that?" It was expected. We didn't do anything that we weren't told to bring to the table. And as we bring this to the table like over and over again, we learn more and more about why we were told to do that, because it works and because we get great programs, like Marie's.

Being Medicaid, it was very hard to sit in the room and hear Medicaid's issues, but we have them. I'm the first one to tell you, we don't do everything right, we don't do

everything nearly right, and so we really had to come and get past that and really come to the table with our idea of what we could do to change.

We wanted to be positioned as a resource to help providers. In our state, Medicaid, public health, and human services, are three separate agencies, yeah. It really, you know sometimes the grass is always greener? Because I look at other states going, okay, you're all in the same agency, you're all under the same director, everything would work, and you're shaking your head, doesn't work. Looks good to me from the outside and you're all looking at me going, "That looks better." We have the same issues. We don't have shared leadership, we don't have shared vision, we don't even have shared staff. So we had to get past all of that and really work with it. We really wanted to honor the family perspective, not because we were only, because we were told to under that \*\*\*\* learning collaborative, but because we really wanted what they had to say. We wanted to hear what we were doing wrong, not just from the providers, but from the people who actually access and use the services. What were the barriers and were they us, were they the providers, were they the system, what were they?

Value added, were we bringing something to the table. We also wanted to be a unified voice for systems change. If Medicaid proposes something, DHS and public health are not necessarily going to go for it, but if we could come up from the bottom and get all of us at the table and take the same up, we had a better chance of making it work.

We also wanted to be, and I know you've heard this word over and over and over again these last two days, collaborative. Collaboration does not flow downhill or even trickle downhill, it has to be there from the beginning.

Our of that learning collaborative came what we're calling the CMHI, or the Colorado Medical Home, if in that we brought everybody together that we thought needed to be at the table, and this is all the way back to 2002. We brought all the agencies together, we brought Family Voices, we brought parents, we brought independent providers, we brought the FQ's, we brought our managed care organizations, and Colorado does not have managed care, just so you all know. But we wanted them at the table because if they ever decided to like Medicaid again, and deal with us again, that we wanted them to be a part of this and we wanted them to know what was going on and know what they were getting into. We brought 501C3's, we brought non-profits, we brought the nursing school. All because we wanted to have the right people at the table to help us make decisions.

We, from the very beginning, had the core concept of families are not asking to be fixed. The system may need to be fixed, but families are not asking to be fixed. We also had to understand the difference between family representatives and family leaders. It was very difficult to go to providers and say, "You know what? We want you to deal with family members who come to your practice." "What do you mean I have to deal with them? They're my patients, I don't want them to tell me how to run my practice." It's not about telling you how to run your practice, we had to really set that aside and look at

what it means to be a family leader, which means you're out there representing families, not your own family.

So what does it mean to be a family in this practice, not what does it mean for me to be in this practice and for my child?

We really invested in the family leadership. We've got two grants going in Colorado to bring up family leaders. Public health, Family Voices, are in conjunction and, Megan, we graduated our first class and we're in our second? Megan's one of our great family leaders, by the way. Hi, Megan!

So what we want to do is we want to position those families not only in practices, but in our advisory boards. Our department has several advisory boards, we would love to have parents who can come in and help us with that. So we're trying to tie all of this together.

We did not do a very good job of, during this entire time, of keeping our legislative representatives and our Colorado Coalition of Medically Underserved, apprised of what we were doing, because they were two people missing at that 75-member table. And they came up with the bill and introduced it. We found out about it two days before it was going to be signed, because we didn't tell them what we were doing, we weren't good at that. We did get some input into the bill, I got input into when it was going to be due, and they got input into what I was going to do.

Our bill is a little bit different, because our bill talks about the accessible, comprehensive, all of that, Colorado law says that a Medical Home can be a physician, it can be oral health and it can be mental health. So now we've just added to that big, old table, because we didn't have oral health there and we didn't necessarily have mental health there. But our law actually says that anybody can be a Medical Home. They just have to want to take on the task of making sure that if they're not a primary provider, of assuring that that child is getting their primary care services. So if I am a mental health physician and I am treating a child who is bipolar, who I am probably seeing more often than the physician, I have to assure that that child is getting back to the physician. We are getting ready to certify our 19th mental health facility as a Medical Home, because they are willing and able to step up.

It mandated that Medicaid and public health had to work together; we just kind of went, okay, we've been doing that for seven years, we can do that. It gave us shared partnerships and it gave us specific tasks. So one specific shared task was coming up with developing standards. We also developed standards, we didn't want these standards to be punitive, we didn't want them to be costly, we didn't want them to scare the providers off. Because when we first started this in 2008, not a lot of providers understood what it meant to be a Medical Home. We'd all heard the term, we all kind of knew what it meant, but nobody really knew what it meant to them as a practice and we didn't want to scare them off. We didn't want to say, "Oh, you're going to have to do this and if you don't do this, then we're going to take funding," because that's what Medicaid

does. You don't do it right, we yank your funding, you don't do it right, we cut the rates. That was the reputation that we didn't want to continue.

So we have the responsibility as Medicaid of practicing transformation and we have partnered with Family Voices to do that, in conjunction with paired practice partnerships or what we call P3's. We have the responsibility of quality improvement and we have the responsibility of reporting the measurements and the successes of Senate Bill 130. We also have the responsibility in reducing ED. At one other time, it just seemed like it was going to be thrown in there, and look at us now, that's where everything is. Public health was to focus on systems change and family leadership. Again, we came out, we set our standards, if you'd like to see them, they're in all the documentation for this presentation online, trying to be green and trying not to print. We had everybody involved, we had NCQA involved in our standards, we had providers, we had the School of Health, we had private providers, we had independent providers, we had nurse practitioners, we had everybody involved in the standards because again, we wanted the buy-in and with the cooperation up front. It was very important to make sure that it wasn't Medicaid saying this has to be done.

We looked at literature outside of Medical Homes. We cross-walked with the NCQA standards to make sure that if providers wanted to go onto that NCQA certification, we were not standing in their way. We sent out more than 5,000 survey monkeys to say, give us your ideas of what needs to happen and what can happen. We wanted to focus on consistent language and we have that CMHI Steering Committee that approved this,

so we could actually say it wasn't just Medicaid. Because I don't know about you, but I didn't want to personally be responsible for telling somebody they had to do something, I wanted everybody's buy in.

So what we learned was quite a bit. We learned that Medicaid should be helping providers. We make it difficult as Medicaid, we don't use the same CMS1500 form, we made up our own. We don't use modifiers, we don't tell people how to do this, this was a big old secret in Colorado, so what we heard very clearly was, you have to help us. So even outside of the Medical Home Initiative, we put in a provider helpline, because we heard very clearly that we were the barrier, and we didn't want to be that barrier in any successes or the cause for failure.

Providers and patients can call, we put that in immediately. We also heard that families were eager for partnerships. We knew that from having worked with the families, but having the families at the table saying that same thing, had a different impact, because it wasn't us saying it. It wasn't the state saying it, it wasn't Medicaid saying it, it wasn't public health saying it, it the parents saying it.

Providers had that format to express fears and concerns where they couldn't be retaliated against. That was one of the things that came up very clearly is, we don't want to say Medicaid's bad if you're going to come down on us. Okay, let me start with everything that's wrong, and you guys take the list from there.

The reimbursement discussion always bubbles to the top, always, always, always, always. We finally put a big old dollar sign on the wall and said, okay, we got it. What else? What else can we do to make this work for the state?

At the time the law came up, I'm not sure that we would've been able to continue on our own. Things were kind of falling apart and in pieces here and in pieces there, but the law kind of revitalized that whole learning collaborative and brought in additional people. We still kept the thought that we were creating a Medical Home to impact individual families.

We still had our continued support of supporting the provider community and we wanted to not reinvent the wheel. It's up here twice because I wanted to make a point, don't reinvent the wheel, it's absolutely not necessary. And Dr. Kraft, we don't have to have a bake sale, because we have so many federal programs that you heard about this weekend that do case management and care coordination. We just need to make it work better. And that's where Colorado went with this. We brought all of the people to the table, Part C, early intervention, care coordination and case management, healthcare program for children with special needs, Nurse Family Partnership, Prenatal Plus, EPSDT, and we got the people in the room who actually run the programs and said, "What are we going to do to make these better?" "What are we going to do to make these work for the provider and what are we going to do to make them easily accessible to both the providers and the families?"

Colorado, in all of this, outside of my time and Eileen's time and Barb's time at public health, put in no money. That law came with absolutely no fiscal amount. But what we did is we found we had the money and we had the right personnel. We just needed to make it work.

We also had built-in measurements, we have the EPSDT416 that looks at preventative care and referrals and oral health, now it doesn't measure immunizations, but that's a whole other store and a fight with CMS.

As a state, we do \*\*\*\* and we also, as a state, decided, again, just like Minnesota, that we are not going to make this an NCQA certification. We didn't want to focus on the care at that time and the specific care that, did all my asthmatics get a flu shot? That's not where we wanted to go, we wanted to go with family satisfaction and provider satisfaction. So we chose to continue using the \*\*\*\* Medical Home Index, it has a provider side and it has a patient side, so we can measure where people are happy with what they're doing.

We also did a pilot program. Our medical director has a saying that I hated in the beginning, and I think I'm one of them, of, get ugly early. We just jumped in, we didn't do a whole lot of planning outside of the meeting and coming up with the standards and really what we envisioned. But there was no planning that went into this. We got grants based on an idea and we ran with it.

In Colorado, because we don't have managed care, managed care is great, managed care is good, managed care saves Medicaid money. So you go deal with the fee-for-service population. So we did. Unmanaged, they were never told they had to pick a Medical Home, they were never assigned to a Medical Home, and our patients to this day can still go wherever they want for care.

We also, because we were tying it into existing funding, tied it into EPSDT. We used our EPSDT federal funds to fund this. The bump goes into our overspending authority line for EPSDT, our enhanced reimbursement, and it's only attached to preventative care. So again, it goes back to EPSDT. EPSDT being Early Periodic Screening Diagnosis and Treatment, God awful name, for a program that means all the care and services for children 20 and under. We just hooked those two together, and we were off and running.

Our Governor, great guy, came in and said, "You know what? All of Medicaid rates are going to 90% of Medicare as of 7/1/08." Then the economy hit. Now they're back down to 87.5%. But it is still higher than some states. With the pay-for-performance, which we're paying \$10 per visit for those 0 to 4 and \$40 for those 5-20, remember, this is a one-time, based on preventative care payment. We also showed them how to reimburse, or how to get reimbursed for children with special healthcare needs using the AAP programs. And we also showed them if they did the developmental screen, that by teaching providers to do all that, we were at the same rate as private insurance. We

match the rates in our state for Pacific Care and United and the Blues. We had to teach them how to do that.

40% of the children, or 47% in the pilot, had a well child visit. Our ED utilization is less, we reduced the hospital, lowered its usage. We also, surprisingly enough, and I don't know why, have lowered our home health rates. Our home health costs have been cut in half for this population. Again, we have a great national project called ABCD, Assuring Better Child Development, we tied into it. It was funded by somebody else, we tied in, we didn't have to do any of the training, and look at our rates. Our screening rates in Colorado have gone up 7000%. Our referrals from physicians have gone up by a huge amount. It used to be soft referral into the programs.

Right now, we have 59.3% of Colorado's children and families who say they have a Medical Home, compared to the national level of 57.5%. We have 245,000 Medical and CHIP clients in Medical Homes, and we have 524 pediatricians, which is every pediatrician in the state, the last ones came on board from peer pressure, peer pressure's not a bad thing. We are now working with family medicine docs and all the clinics. All of our CHP Plus managed care contracts participate. They jumped on board a year ago, because they were in the planning process, they knew what we were doing and they knew why it was happening.

So again, if I have to say anything, it's don't reinvent the wheel, go after what's out there, especially in this day and age where we don't have any extra funding. And

remember that we're redoing a system where parents have been the case managers and the caregivers for their kids with special needs for about 20 years. Don't invent a system if you haven't asked them what they want. Because I don't know about your state, but in our state, if our families aren't happy, we're not happy.

Everybody still awake? I do see some nods. Great.

MICHELLE: Thank you, thank you to our speakers, all of you. We do have some time for discussion and questions.

UNKNOWN SPEAKER: \*\*\*\* care coordination and case management, specifically \*\*\*\* where the Medicaid population \*\*\*\* might not qualify for \*\*\*\* how have you all been able to access this kind of service for private \*\*\*\* because that seems to be a place to me where there's a hole.

GINA: What we've actually done is HCP does not care about payment source, Part C does not care about payment source, and our family navigators through Family Voices Colorado have picked that up. So again, we're using the things that are out there for that particular population.

UNKNOWN SPEAKER: And in Minnesota, commercially insured children will be part of the payment methodology for certified healthcare homes. The only group that isn't included are the private employer groups, the ERISA group, which is about 58% of the

consumers in our state, but we are just sitting down at the table and starting to work with them and a number of the larger groups are working on it, and our statewide employee group is included as well.

UNKNOWN SPEAKER: Can you describe your Medicaid system where \*\*\*\* to being certified, like how do you go about reimbursement \*\*\*\*

UNKNOWN SPEAKER: The way it works in Minnesota is that we have our Medicaid Department is under the Department of Human Services and then we have the Department of Health in a separate structure, and so we're actually working together in a combined project implementation and in our law related to the reimbursement portion of it, it says that the Medicaid, we will develop a payment methodology for Medicaid and all the other commercially insured patients that fall under the state's regulation will implement a system consistent with.

So we actually have developed then, the care coordination payment rate for Medicaid patients and Medicaid actually just set their rate this past week.

UNKNOWN SPEAKER: \*\*\*\* fee for service kind of thing or \*\*\*\*

UNKNOWN SPEAKER: We decided—

UNKNOWN SPEAKER: \*\*\*\* Medicaid?

UNKNOWN SPEAKER: Well, we looked at a variety of different payment methodologies and at this point, because fee for service is the way that we get paid in Minnesota, we decided to implement it as a per-person, per-month payment and it is risk adjustment based on using condition groups similar to the ACG's, the John Hopkins ACG's. And so there's a tool, and we decided that it really isn't the pair that decides the patient's risk level, but it really is the provider and the care team and the patient together.

And so we have a tool and based on the number of major conditions, it's stratified into five risk groups, and there's a payment, a care coordination payment based on each of those groups.

And the details are found on our website if you're interested.

UNKNOWN SPEAKER: Same question, Mary, did you—

UNKNOWN SPEAKER: \*\*\*\* what is the \*\*\*\* for oral health providers and mental health providers? Is there, to be a Medical Home? Is there a \*\*\*\*

UNKNOWN SPEAKER: No, surprisingly enough, what we found from that original \*\*\*\* collaborative is that payment wasn't necessary, providers really wanted to be in this to do the right thing and we're finding that's still proving true with oral health and mental

health. There's absolutely no incentive for them and yet they are banging on our door to participate.

UNKNOWN SPEAKER: \*\*\*\* quality improvement project \*\*\*\* re-certification and \*\*\*\*

UNKNOWN SPEAKER: Yeah, they do. And really what we're finding is, the quality improvement projects are really leaning toward the notification of either the specialist or the primary provider or, you know, just the simple things that we think happen that really don't. Like, you know, this is why I'm sending this patient to you, type thing, like we heard from Dr. Kraft, like she does. A lot of providers don't do that. So their quality improvement is based on getting them into the rhythm of doing those things.

UNKNOWN SPEAKER: I have a question \*\*\*\* Minnesota \*\*\*\* set your care coordination fee, is that a core principal, like \*\*\*\* sort of team-based care, so the payment goes to the \*\*\*\* for filing, you know, presenting a plan or something that says we have met this criteria so we should get this added payment. Do you have any sense whether that payment are filtered down to other members of the team or how would that be, if there's any distribution or redistribution of that fee, or just—

UNKNOWN SPEAKER: Well, that's a really good question and I can answer that in multiple ways, based on what we've been hearing. First of all, we did add an RVU value to the care coordination payment because we do recognize that a lot of providers are reimbursed based on, you know, their RVU value. And we know that some

organizations, we've seen their CEO stand up and say all the care coordination dollars are going to be passed along to primary care in order to pay for additional care coordination. There are other organizations that plan to have the care coordination fee be distributed among the members of the healthcare team, whether it's specialty care or primary care and there are others, I imagine it'll go into the proverbial organization melting pot.

It's a really, it's a real point of discussion, especially between the specialists and primary care. In order to become certified in Minnesota, you have to provide the full scope of primary care services. So you could be a specialist that is providing the full scope of primary care services, but when the specialist is doing a big chunk and the primary care provider may not do all of the rest, there's sort of this, well, gosh, how come the money isn't coming into specialty and we're saying, that's up to your organization to figure out how you're going to stratify those dollars within and of course, also, we'd looking at some of the ACO kinds of models around care coordination as well.