Assessment of Ohio's Enhanced Primary Care Home Initiative

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Introduction

Ohio's Enhanced Primary Care Homes represent an evolutionary step, building on the classic model of a Patient-Centered Medical Home (PCMH).1 Defined as "an enhanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive and coordinated patient-centered care," 2 Ohio's Enhanced Primary Care Home (EPCH) model differs from the classic PCMH model. Specifically, it includes the potential for a primary care home to be led by an advance-practice nurse, incorporates behavioral health into the model, and includes team-based care as a foundational goal.

PCMH efforts in Ohio began in earnest in 2007, with the Cleveland and Columbus projects; these were followed by efforts in Cincinnati that began in 2009. The Cleveland and Cincinnati projects are associated with the Robert Wood Johnson "Aligning Forces for Quality (AF4Q)" initiative (http://www.rwjf.org/qualityequality/af4q/index.jsp). This ongoing initiative focuses on practice recruitment and engagement to transform to the PCMH model of practice, with certification by the National Committee for Quality Assurance (NCQA) as Level 1, 2 or 3 PCMH Practices (http://www.ncqa.org/tabid/631/default.aspx) listed as one measure of success for practices within these project sites.

In 2009, the Health Care Coverage and Quality Council (HCCQC) embarked on the development of a statewide medical home initiative, pulling together a steering committee to oversee the initiative's development and implementation. In addition, in 2010, Ohio House Bill 198 (HB198) established the "Enhanced Primary Care Home Education Pilot Project," designed to support selection of up to 44 primary care practices affiliated with select medical or nursing schools in the state. The law also supported efforts to reform the curriculum in medical and nursing schools to effectively prepare the health professions workforce to function in medical home practices and to pioneer efforts to disseminate this model of care into the state's practice environment. Funds from the HCCQC were used, in part, to support practice transformation and expansion efforts in existing projects in Cincinnati, Columbus, and Cleveland, as well as to support the site selection process for projects under HB198. During the period covered by this report, the HB198 Education Advisory Group, with support from the four emerging projects, successfully selected 44 practice sites (37 physician-led and 7 nurse-led) to participate in this work.

The practice consulting firm, TransforMED (www.transformed.com), assisted in developing and implementing a selection process for choosing among candidate sites for the emerging projects. TransforMED also assisted some, though not all, of the existing projects with a structured transformational process of PCMH model adoption. The Ohio Academy of Family Physicians (OAFP) served as administrative coordinator for the funding and oversight of the HB198 efforts to create the emerging projects.

This assessment relies on key informant interviews with project leaders and key personnel involved in seven EPCH projects in Ohio, at OAFP and TransforMED. Written project status reports from each of the projects were reviewed and findings included in this report. Funding was provided for the EPCH initiative by the HCCQC from November, 2010 – June, 2011. The assessment covers project efforts during that period and is designed to identify best practices, key challenges and next steps for advancing the Enhanced Primary Care Home effort in Ohio as state policymakers and stakeholders proceed to implement key provisions of federal health reform legislation (Patient Protection and Affordable Care Act or ACA).

Key Informants

Interviews were conducted with the following individuals (affiliations noted):

- Jeff Biehl, MBA – Access Health Columbus, Columbus
- Sara Blocher, Project Manager -- Health Improvement Collaborative of Greater Cincinnati, Cincinnati
- Larry Brumleve, CPC, Practice Enhancement Facilitator - TransforMED
- Randall D. Cebul, MD - Better Health Greater Cleveland, Cleveland
- Anthony Costa, MD – Emerging EPCH Project, Northeast Region
- Linda French, MD – Emerging EPCH Project, Northwest Region
- Jane Hamel-Lambert, PhD – Emerging EPCH Project, Southeast Region
- Kate Mahler, CAE – Deputy Executive Vice President, Ohio Academy of Family Physicians
- Tracy Riley, PhD, RN – Emerging EPCH Project, Northeast Region
- Ann Spicer – Executive Vice President, Ohio Academy of Family Physicians
- Barbara Tobias, MD – Health Improvement Collaborative of Greater Cincinnati, Cincinnati
- Patricia Vermeersch, PhD, RN, GNP – Emerging EPCH Project, West Central Region

Background

The Patient-Centered Medical Home (PCMH) concept was pioneered by a group of primary care specialty societies (American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and American Osteopathic Association) and has been at the forefront of health system redesign efforts for a number of years. As advocacy for and evidence supporting this model has grown, it has been incorporated into numerous regional and local health system reform efforts and included in the Patient Protection and Affordable Care Act3 as a part of national health care reform.

A major national demonstration project of the PCMH model was undertaken in 2006, and evaluation data from that demonstration project indicated that the model could be implemented in "highly motivated practices;" requires a significant commitment of two years or longer, with leadership, resources and outside facilitation of the process of practice transformation; improves patient care; and can be widely disseminated "if sufficient time and resources are made available." 4 More recent outcomes from this demonstration project indicate that, after two years of practice transformation, there were improvements in health care access, condition-specific quality measures, prevention outcomes, and chronic care management outcomes, but no improvement in patients' experience of care.5

Rigorous project-specific evaluations are few in number, but at least two studies are cited frequently. The first demonstrated that North Carolina Medicaid's efforts to incorporate PCMH with a care coordination fee and a per-member-per-month (PMPM) fee saved the state as much as $124 million in 2004.6 The second study reflects efforts at the Geisinger Health System (Pennsylvania) to incorporate PCMH. Geisinger implemented a flat fee of $1800 per provider, plus $5 per Medicare patient per month ($5,000 per 1,000 Medicare covered individuals) "transformation stipends" to cover the costs of PCMH implementation including using nurse coordinators, care management support, open access scheduling, and electronic health records. These efforts resulted in a 20% decrease in hospital admissions and a 7% overall savings in medical costs for the Geisinger system.7

Efforts to foster health system redesign and innovation have also been promulgated by the Centers for Medicare and Medicaid Services (CMS) through its new Center for Medicare and Medicaid Innovation (CMMI) created in November, 2010.8 A national collaborative has been established to seek consensus around a set of evaluation metrics for success in such initiatives, and the work of this collaborative has provided a foundation for the development of Ohio's efforts.9 A defined research agenda is well underway at the national level, and is contributing to the dissemination of this group's efforts to develop a standardized evaluation methodology. 10

A systematic review of the evidence regarding PCMH implementation was provided by Grumbach and others, revealing that "quality of care, patient experiences, care coordination, and access are demonstrably better" under this model and that investment in this model "result(s) within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs."11 Efforts are underway to define a national research agenda with systematic measures that address health care costs and efficiency of care.10 These and future studies must address issues of effectiveness from the perspective of the "triple aim" proposed by Don Berwick, MD, founder of the Institute for Healthcare Improvement and current Director of the Centers for Medicaid and Medicare Services (CMS)--specifically to reduce the cost, improve the quality, and enhance the patient's experience of care.12

Several barriers to successful PCMH model implementation have been identified.13 They include limited time for providers to participate in practice transformation activities; penetration of electronic health records and the

infrastructure and capital expenditures needed to adopt and maintain those systems; broad definitions of the model which make it difficult, particularly for smaller practices, to meet National Committee for Quality Assurance (NCQA) guidelines; and resistance from both providers and consumers to the transformative nature of the changes required in medical practice to fully implement this model. Given these barriers, and the environmental landscape of the health care delivery system change in this decade, such as the development of the "medical neighborhood"14,15 in which the medical home must thrive, patient-centered care is changing drastically and rapidly. Local clinical practice infrastructures, hospitals and health systems and their emerging Accountable Care Organizations, other health professionals (including behavioral health, pharmacy, dentistry and others), the local network of community health agencies, and the public health practice infrastructure all must become part of the "neighborhood" in which the medical home will best function and allow patients and providers to thrive. This integration is critical to understanding the long-term trajectory of transformational change required of health care practice in this country.

Many patients and providers have concerns that this movement is simply another in a series of health reform efforts that really focus on cost-savings, though the words "patient-centered" are at the core of the name. A proposed definition of "patient-centered care" again from Don Berwick, MD, is, "the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."16 This assessment seeks to define progress toward the goal of implementing true patient-centered care for the State of Ohio's health professionals, patients, and payers.

Methods

The following report relied upon hour-long key informant interviews conducted by telephone, with the nine project leaders listed in this report, conducted between April and June of 2011. In addition, two project leaders from the Ohio Academy of Family Physicians and one consultant from TransforMED were interviewed about their experiences with the project, for a total of 12 interviews.

A semi-structured interview was conducted utilizing the questions noted in Appendix 1. Each interviewee completed an informed consent process, and the project was reviewed and approved as human subjects research by the Institutional Review Board of the Northeast Ohio Medical University (formerly Northeastern Ohio Universities Colleges of Medicine and Pharmacy). In addition, project reports provided by each of the projects to the Ohio Colleges of Medicine Government Resource Center related to funding for the EPCH Initiative were utilized for background information.

Projects

Ohio is home to three existing and four emerging EPCH Projects. The existing projects include Access HealthColumbus; Better Health, Greater Cleveland; and the Health Improvement Collaborative of Greater Cincinnati . The emerging projects are housed at the Boonshoft School of Medicine (Wright State University) – West Central Region; University of Toledo – Northwest Region; Northeastern Ohio University Colleges of Medicine and Pharmacy – Northeast Region; and Ohio University – Southeast Region. It is important to note that there were two distinctly different types of projects involved in these interviews. Projects in Cincinnati, Cleveland and Columbus have been in existence between one to three years and have several affiliated practices that have been highly engaged in the process of practice transformation for most of that time. In those project sites, there are identified practice partners, varying degrees of engagement with payers, well-developed learning collaboratives, and an increasingly robust plan for measurement of near and long-term outcomes. Project leaders who participated in interviews for this assessment were very insightful about the specific successes and challenges they encountered to date and about their plans for sustainability and growth.

In collaboration with the four emerging projects, the HB 198 Education Advisory Council completed selection of 37 physician-led and 7 advance practice nurse-led sites in the regions to participate in the next round of EPCH practice transformation. In these emerging projects, the close connection between EPCH development and targeted EPCH training and curriculum reform at affiliated universities is a prime component of the project. While these projects have not begun the process of transformation with the selected practices, leaders of these emerging projects have provided significant insight into the issues facing practices to be affiliated with their projects. The key informants for each these projects provided insight into the development of the projects and discussed potential challenges and successes each expects to encounter. Table 1 summarizes descriptive information for each of the project sites.

Existing Projects

Health Improvement Collaborative of Greater Cincinnati – Cincinnati (http://www.the-collaborative.org/): This project began with 11 practice sites in October, 2009, with three payers recruited to provide enhanced per-member per-month (PMPM) payment to those practices. It is part of the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality (AF4Q) Initiative. In addition to the initial 11 "pilot" practices (Pilots), 9 additional practices joined with no guarantee for the PMPM payment (Co-Pilots). The 11 Pilot and initial 9 Co-Pilot practices all applied for NCQA certification and were successful in achieving certification at the practice-selected level. Of these practices, 7 achieved Level 3 certification, 2 achieved Level 2 certification, and 1 achieved Level 1 certification. Individual on-site practice coaching was provided by a local consultant, and the Pilot practices received consultation from TransforMED. Efforts are underway to recruit and work with an additional 20 Co-Pilot practices, and the project intends to begin the NCQA certification process with these practices by fall of 2011. Learning collaboratives provide a key means of dissemination for best practices among the practices in this project.

Better Health, Greater Cleveland (http://www.betterhealthcleveland.org/): This initiative began in 2007, and is also part of the RWJF Aligning Forces for Quality Initiative. It serves over 500 physicians in 48 safety net practice sites, including practices affiliated with such diverse organizations as the Cleveland Clinic and local Federally Qualified Health Centers (FQHCs) serving the homeless population in Cleveland. These clinics are in various

stages of application for and achievement of certification through the NCQA process, with approximately a dozen having achieved certification at the time of this report. The project focuses on providing tools for those practices interested in PCMH transformation. The toolkit emphasizes key elements related to effective use of electronic health records in optimizing patient and population health, and the project has adopted a validated depression screening instrument as a standard among its practice sites. The project has supported a psychologist, who formed and led a committee of behavioral health professionals to recommend protocols for incorporating depression screening in primary care practices for patients with diabetes, heart failure and hypertension. Learning collaboratives are a key method for dissemination of best practices among and between these practices and are a key success of this project. The project recently recognized 32 practices with quality scores in the top 10% of measurement categories (http://www.betterhealthcleveland.org/Community-Health-Checkup/Gold-Star-Practices,-2009.aspx).

Access HealthColumbus (http://www.accesshealthcolumbus.org/): Launched in 2007, this project began with feasibility and pilot studies aimed at developing a process for supporting PCMH practice transformation in the greater Columbus area. Nine practices in a first wave became the first NCQA-certified Patient Centered Medical Homes in central Ohio as of 2010. With funding through the HCCQC's EPCH initiative in 2010, an additional 18 practices were enrolled in the project and are on target to complete NCQA certification by fourth quarter, 2011. The project includes a learning collaborative for dissemination of best practices, a "best practices incubator", and a consumer engagement initiative to promote medication adherence. Evaluation metrics are established, and data collection is progressing, with analysis slated for completion and reporting by July, 2011. Seven payers have engaged with commitments to incentivize practices for implementation of PCMH. Efforts are underway to recruit an additional three payers to support this project during 2011.

Emerging Projects

The four emerging projects supported by this initiative are housed in either a College/School of Medicine or a College/School of Nursing. Table 1 provides a description of each of these sites. Practice sites selected for transformation were required to have educational affiliation agreements with either a College/School of Medicine or a College/School of Nursing. TransforMED was retained to assist with development of this initiative, including development and completion of a practice selection process and consultation in the development of educational outcome metrics. The Ohio Academy of Family Physicians has served as the project's fiscal agent and provides logistical support for the organization of the process of site selection and development of a working infrastructure of committees to move the process and its work forward.

A total of 65 applications were received from primary care practices across the state to be considered for 44 demonstration sites. The process of working together across disciplines was productive and has resulted in more collaboration between nursing and medicine to consider team-based learning initiatives and the development of enhanced medicine and nursing curricula to train practitioners to practice in the EPCH model. No explicit outcomes on a practice-site level have been achieved to date, as the final selection of 37 physician-led and 7 advance practice nurse-led clinics just occurred. The practices selected now await funding to support practice transformation efforts and development of potential funding streams is underway. Through collaboration with the Governor's Office of Health Transformation, Ohio Department of Health, Ohio Department of Job and Family Services, and others, it is hoped that such funding will be obtained and that emerging project EPCH implementation efforts will continue.

Interview Findings and Results

Appendix 2 provides a detailed, aggregated and de-identified summary of responses to each of the interview questions. Interview transcripts were created by the interviewer (Hull) for each interview, and all responses were summarized by expert assessment (Hull). Key findings from these interviews are summarized below. The denominator for all responses is the total number of interviewees (n=12). The order of listed responses is based upon the order of the questions asked in the interview and does not indicate relative frequency or importance of the responses.

Scope of Practice Engagement (See Table 1)

- Between 11 and 48 practices are engaged in each of the existing projects.
- Most affiliated practices in existing projects are planning to seek NCQA certification, and many have already achieved certification at the level applied for (3 projects).
- Several project sites have indicated that NCQA certification is a necessary, but not sufficient step in practice transformation, and that this designation alone is "only the beginning." (3 projects)
- At least two projects involved with rural practices indicated some challenges with NCQA certification unique to rural practices, including lack of access to high-speed internet services.
- Emerging practices have just completed the process of practice selection and are beginning the process of engaging those practices in planning for transformation. (4 projects)
- Emerging projects have been deeply engaged in the process of curriculum transformation in partnership with affiliated health professions schools. (4 projects)
- All projects indicate a need for future funding to continue to support affiliated practices in the transformation process.

Payer Engagement (See Table 1)

- Existing projects have engaged between 3 and 7 payers with commitments to support some or all affiliated practices in transformation efforts. (2 projects)
- Emerging projects have had varying degrees of engagement with payers, mostly through attendance at "Town Hall Meetings" held to recruit affiliated practices. (2 projects)
- At least three projects suggested use of data from evaluation of PCMH initiatives (National Demonstration Project, reports from Geisinger implementation and North Carolina Medicaid) to make the business case to payers.
- At least 3 projects discussed early engagement of payers, working with them "early and often" and developing ongoing relationships.
- Payers have supported a number of pilot projects and are ready to see results.--"They need to see whatever you do is going to save them money." (4 projects)

Outcome Measures – Planned and Active

- At least two projects are using or plan to use one or more of the following measures as part of

their ongoing evaluation of project outcomes:

- Consumer Assessment of Health Care Providers and Systems (CAHPS), developed by AHRQ and publicly available
- CAHPS Medical Home Questions (under development by AHRQ and publicly available)
- Patient Activation Measure (developed by Insignia Health, http://www.insigniahealth.com/solutions/patient-activation-measure)

- At least two projects are using or plan to use the Maslach Burnout Inventory (http://www.mindgarden.com/products/mbi.htm), as recommended by the HCCQC's EPCH Evaluation and Outcomes Workgroup, to measure provider and staff burnout.
- The ability to collect cost and utilization data depends in large part upon development of robust relationships with payers, allowing access to their proprietary data on these outcomes. (3 projects)
- Several project leaders suggested that the experiences of care and of practice transformation for the patient, family and community should be considered in evaluation plans. (5 projects)

Key Successes

- NCQA recognition was mentioned by several projects as a benchmark of success (4 projects), though at least 3 project leaders suggested that this benchmark alone was not sufficient, nor did it indicate that sustainable practice transformation was complete.
- Participation of safety net practices willing to share their outcomes and benchmarks with more highly resourced practice systems, and seeing those highly resourced systems willing to share their "best practices," were noted to be key successes. (1 project)
- Having a large number of applicants for the Emerging Project site selection process was cited by all four Emerging Project leaders as a successful outcome.

Key Challenges

- Lack of identifiable and ongoing funding streams to support practice transformation across the state. (5 projects)
- Obtaining "buy-in" and support from payers to participate in ongoing statewide payment restructuring. (7 projects)
- Payment reform that includes PMPM fee for care management, fee for service for routine care and a pay-for-performance component. (1 project)
- Reform of the mental health payment structure to integrate behavioral health. (3 projects)

Burnout and Staff Turnover

- Several projects noted that "taking on too much" or trying to implement practice transformation too fast would lead to burnout for both providers and staff, and they noted that patients also have a negative experience when this occurs. (4 projects)
- Implementation of Electronic Health Records is not easy, and the rewards have not been fully realized in many places. Many practices experience burnout for staff and providers during the adoption phase for EHR. (4 projects)
- Those practices excited about the transformation process and highly motivated to complete the work have less difficulty with burnout than those who are not as highly motivated, but it is still

hard work. (3 projects)

High-Volume Medicaid Practices

- These practices, including but not limited to Federally Qualified Health Centers (FQHCs), face economic and volume-driven challenges, and find it harder to make time for providers and staff to accomplish transformation. (3 projects)
- These practices seem to have a harder time adopting EHR, though many have successfully done so. (3 projects)

Behavioral Health Integration

- No project leader reported full implementation of behavioral health integration in any of their affiliated practice sites.
- Where screening for mental illness occurs, the practices that do this are focusing on either depression or anxiety, or both. (3 projects)
- At least 3 project leaders identified shortages of mental health providers with terminal degrees (particularly PhD-level psychologists and physicians in psychiatry and child psychiatry), especially in rural and underserved areas.

Utilization of Health Care Teams

- No project leader reported having fully-functioning, multidisciplinary or interprofessional health care teams in place.
- A "best practice" suggestion was made that practices should include two kinds of team meetings:
  - One organized to discuss complex patients and problems and solving those problems, and;
  - One process-oriented meeting to discuss interpersonal and interprofessional issues as they arise.
- One project leader said, "'Team' means understanding and recognizing and rewarding what everyone can do to take care of the patients and families coming into your practice."

College and University Involvement in EPCH Initiative

Suggestions were made for enhancing the participation of colleges and universities in supporting and disseminating EPCH models to health professions learners.

- All project leaders suggested that transformation of health professions curricula to include EPCH principles and creation of opportunities for interprofessional learning from "role-model" teams was critical to successful dissemination of this approach.
- The need to create incentives for learners in the health professions pipeline was cited by over half of those interviewed.
- Two project leaders offered the reminder that those who are already out in practice will need to be trained in the EPCH model, and suggested that colleges and universities could take the lead in reaching this population.

Best Practices and Advices for those considering Practice Transformation

All project leaders contributed suggestions for those practices considering practice transformation. Included here are suggestions for "best practices" and cautions about facilitating factors and barriers to implementation, distilled from interviews with some of those most experienced in EPCH implementation in the state.

- **Best practices in cultural transformation to support EPCH implementation:**
  - Practice transformation has to be both a transformation of the practice/office thinking and a transformation of business practices and processes.
  - Cultural transformation has to "lay the groundwork" for the process changes.
  - The practice must be motivated and dedicated to do this work. The effort is "not for the faint of heart," "not for those who just want to 'see what it's all about.'" This theme was echoed by four project leaders.
  - If practices set out to achieve NCQA certification just to get higher rates of reimbursement, they will not be able to sustain the magnitude of change required for full implementation, and they will be frustrated. (4 project leaders)

- **Best practices related to the process of EPCH implementation and sustainability:**
  - "Look through things first to get your head around all of the different pieces. Pick a very small piece that you have a 95% chance of accomplishing over the next three months. . . Get everyone on board, give them a vision, and help them understand. If (you) bite off too big a piece, (you) will get discouraged and give up."
  - Multiple project leaders stressed that communication, leadership and teamwork are required.
  - Several project leaders cautioned practices not to take on too much at the beginning of the process.
  - Achieving NCQA recognition alone is neither sufficient nor sustainable. (stressed by multiple project leaders)
  - Select an EHR product that is capable of supporting robust data mining so that continuous quality improvement initiatives can be sustained.
  - Having a clinician "champion" and an administrative "champion." (4 project leaders)
  - Offering monetary incentives for practice representatives to attend learning collaborative meetings. (2 project leader)
  - "Invest in care coordinators and other interprofessional team members – they are part of what makes this model really work."
  - "Perseverance matters – the tensions teach!"

- **Best practices in payer engagement:**
  - Use national data to make the evidence-based argument for implementation of payment reform to support EPCH implementation.
  - Invite payers early and often, and engage them in learning collaboratives.
  - Continue to discuss the need for payment reform to sustain the PCMH model.

- **Potential barriers to implementation:**
  - Failure to engage payers makes it difficult to achieve sustainability.
  - Lack of access to high-speed internet resources may be a limitation for rural practices.

- Small margins and high need for practice productivity may be particularly challenging for safety-net practices as they try to implement EPCH.

A seminal quote from one project leader sums up the feeling of many of those interviewed: "A lot of things have happened with Patient Centered Medical Home transformation practices across the country: better patient outcomes, better physician satisfaction within the practice, better office staff satisfaction, better patient satisfaction because of increased access to care. Even where there is no payment reform, efficiencies have improved, so bottom line has improved, because expenses go down . . . We know that we do better patient care out of this model. That's really what we are all about. If we did nothing else, that's what doctors should do. Even if we didn't get paid a dime more, this model does everything else right."

Discussion

The interviews conducted for this assessment describe experiences from across the state, in rural and urban locations, with highly-resourced and less-highly-resourced practices, representing a diverse patient population. There is a great deal of excitement in the field about implementation of the EPCH model, and its potential to improve patient outcomes, patient experience , provider satisfaction, and quality of care, all while reducing costs within the system.

Motivation of staff and providers to undertake transformational change is critical to ensure success of these efforts, and high levels of practice motivation for participation are a key factor in successful EPCH implementation. Burnout among all personnel involved in the effort can be significant, and must be considered Ongoing support for staff and providers through learning collaboratives has been successful in the existing projects in terms of keeping motivation high, learning from colleagues' successes and challenges, and generally keeping the energy positive for continued change.

Efforts to integrate behavioral health and robust, interprofessional health care teams are beginning, but are not widely nor fully implemented. Payment reform will help drive this, and engagement of Ohio Medicaid in that process is necessary for this proposition's value to become clear to providers. At the same time, payers, including Ohio Medicaid, will need to see widespread uptake of the model before the "business case" for changing payment models becomes clear. This tension will require collaborative discussion, and the feeling of those interviewed was that this collaborative discussion has begun, particularly in the existing project areas. Those affiliated with emerging projects had not seen as much success in this area, and may benefit from a statewide discussion with the existing projects about their efforts to engage payers.

Curriculum reform in health care professions education is critical to provide early exposure and long-term acculturation of new professionals into this model as the "standard of care." The HB198 Education Advisory Committee and the emerging projects are poised to do this well, and those interviewed believe that participation of universities and colleges in robust curriculum transformation will help prepare the next generation of providers for practice using this model. They stress the need for development of "role model" teams to demonstrate to students the best practices necessary to practice in this environment and the need for interprofessional curriculum development to achieve this.

Technical issues exist related to information technology, particularly in selection of EHRs that will support data mining at the level required for ongoing quality assurance at the practice and population levels. In addition, rural practice sites still struggle with access to high-speed internet services, where this limits the ability to participate robustly in EPCH projects. Most project leaders interviewed cited the up-front costs of EHR implementation but believe that efforts are underway to support this going forward. Efforts to improve this infrastructure, and continued efforts to develop support for practices in selecting and implementing EHR will be helpful. EPCH implementation and expansion issues remain, with many of them revolving around the need for ongoing funding to support transformation activities, demonstration projects, and payment reform so that the model can become institutionalized throughout the state. Many of the suggestions by project leaders interviewed for this assessment focused on securing funding for future support for EPCH implementation statewide and for implementing systematic payment reform that incorporates behavioral health and support for health care teams. As the Office of Health Transformation, ODH and JFS continue their task of modernizing the state's health care system, these state agencies

will play an integral role in supporting EPCH efforts and will lead the way for relevant policy changes, including funding mechanisms that will support the further development and expansion of EPCH projects across the state.

Next Steps

Given the discussion above, the following are offered as potential "next steps" for taking EPCH implementation to the next level in the state and securing institutionalization of the model across the state.

- Enact payment reform that mandates PMPM payments in addition to fee for service and pay for performance for all insurers in the state. Successful advocacy efforts at the state level will enhance the ability of providers and practices to carry out significant reform utilizing the EPCH model.
- Along with payment reform mandates for payers, initiate an incentive-based requirement for providers. Both may need to happen simultaneously for either payers or providers to believe that each is going to participate in a meaningful way.
- Align reimbursement to favor integration of behavioral health and interprofessional health care teams into primary care by:
    - Activating payment for CPT codes that support or enable mental health providers in the primary care setting to deliver services to patients; and
    - Activating consultation and team management codes that would help support full implementation of the most effective team components of EPCH.
- Convene a statewide conference of existing and emerging project leaders to discuss best practices to engage payers, focusing on key learning from existing projects and development of implementation strategies for the emerging projects. Consider inviting payers to participate so that emerging projects have a chance to discuss EPCH implementation with regional payer representatives. This could evolve into a statewide EPCH Project Leaders' Learning Collaborative, modeled on similar efforts at dissemination of best practices within each project.
- Continue to provide technical support for practices choosing EHR products that will support the EPCH implementation process fully. This may take the form of statewide collaboratives that are already underway but could include educational activities specific to regions and their needs (rural/urban/suburban/Appalachian) or to various types of practices (FQHCs, safety net clinics, private practices, hospital-based practices).
- Conduct a systematic review of regulations for telehealth services and their impact and potential alignment with needs in rural and urban underserved areas to fully implement EPCH.
- Conduct a systematic review of regulations and funding that impact access to high-speed internet services, particularly in rural areas to ensure that providers have the tools needed for full implementation of EPCH.

Conclusions

This report relies on consultation with a number of experts "on the ground" in Ohio who are working to implement EPCH principles across the state Shared experiences represent a tremendous amount of time, talent and energy from those committed to this model. Assessment results show great commitment among project and practice leaders, providers, and payers, to this model of care. Many believe that the EPCH model will allow providers to "practice the kind of care they always wanted to." This enthusiasm and commitment to Ohio's healthcare consumers bodes well for the continued success of the initiative.

Table 1: Project Summary Table

EPCH Project	Project Status	In Existence Since	Deliverables	# of Practice Sites Involved with NCQA Certification Status	Types of Practices	Engagement With Payers
Cincinnati, *Health Improvement Collaborative of Greater Cincinnati (http://www.the-collaborative.org)*	Existing	2009	-Practice Coaching -NCQA Certification -Learning Collaboratives	20 practices; all have successfully applied for NCQA certification	Includes FQHCs, private and hospital-based practices	3 payers participating in enhanced per-member-per-month (PMPM) payment for initial 9 practices
Cleveland, *Better Health Greater Cleveland (http://www.betterhealthcleveland.org)*	Existing	2007	-PCMH Toolkit -White Paper	48 practices; approximately 12 have achieved NCQA certification	Includes employed physicians from large health systems, including safety net system; FQHCs; free clinics and private practices	Have commitments from multiple payers and are engaged in robust discussions on payment models to support PCMH in *Better Health* partner practices
Columbus, Access HealthColumbus (http://www.accesshealthcolumbus.org)	Existing	2007	-Practice Coaching -NCQA Certification -Payer/ Employer Engagement - Advancement of Consumer Engagement Strategies	27 practices in two "waves," First 9 have achieved NCQA certification; remaining 18 are on target to complete application by Q4, 2011	Includes FQHCs, private and hospital-based practices	7 payers participating with commitments to incentivize practices; efforts underway to recruit an additional 3 payers during 2011
Akron, Northeast Region EPCH Project *(Northeast Ohio Medical University and University of Akron College of Nursing)*	Emerging	2010	-Recruit at least 11 practices	Participating in practice site selection	Physician- and nurse-led clinics with educational affiliation with at least one School/College of Medicine or Nursing	Discussions underway

EPCH Project	Project Status	In Existence Since	Deliverables	# of Practice Sites Involved with NCQA Certification Status	Types of Practices	Engagement With Payers
Athens, Southeast Region EPCH Project *(Ohio University)*	Emerging	2010	-Recruit at least 11 practices	Participating in practice site selection	Focuses on rural practices; physician- and nurse-led clinics with educational affiliation with at least one School/College of Medicine or Nursing	Discussions underway
Dayton, West Central Region EPCH Project *(Boonshoft School of Medicine, Wright State University)*	Emerging	2010	-Recruit at least 11 practices	Participating in practice site selection	Physician- and nurse-led clinics with educational affiliation with at least one School/College of Medicine or Nursing	Discussions underway
Toledo, Northwest Region EPCH Project *(University of Toledo)*	Emerging	2010	-Recruit at least 11 practices	Participating in practice site selection	Physician- and nurse-led clinics with educational affiliation with at least one School/College of Medicine or Nursing	Discussions underway

Appendix 1- Semi-Structured Interview Questions

Site Leader and Key Thought Leader Interviews – Semi-structured Interview Questions

These questions will be asked of the identified project leader during the telephone interview and will be reviewed with various site personnel during the site visit interviews. Other issues that arise will be noted and included in the report.

1. Tell me a bit about your project – the 50,000 foot view – how would you describe it to someone who did not understand EPCH?

2. Who are the providers that you are currently working with (please provide a comprehensive list). What service/resources do you provide to the providers who are implementing the EPCH model?

3. Of the practices that you are working with, how many are in each of the following phases of implementation?
   a. Deciding whether to adopt the EPCH model;
   b. Have decided to adopt the model and are making changes necessary to implement;
   c. Have fully implemented the EPCH model.

4. How are you monitoring your progress related to this initiative? What performance measures are you collecting?

5. What do you think are your key successes?

6. What do you think are your key challenges?

7. From your perspective, what are the key factors that support successful implementation of practice transformation to an EPCH model?

8. What advice would you give to practices that want to adopt this model?

9. To what extent and in what fashion do you feel that burnout has impacted or will impact your implementation of the EPCH model?

10. How would you describe your work with insurance payers to participate in your EPCH Initiative? Please describe which payers you have worked with, your efforts to engage them, outcomes of those efforts, and next steps.

11. Please describe your efforts to work with high volume Medicaid practices.

    a. Of the practices that you are working with, how many would consider Medicaid to be one of their primary payers?
    b. What have been the barriers to integrate these practices in your initiative, if any?

12. If you were giving advice to someone about how to work with payers (insurance companies/health plans/ others) to achieve their buy-in for an EPCH model, what would you suggest?

13. Do you have any documents you could share that identify the key organizational leaders in your each EPCH site that you work with? This information will be kept confidential except for purposes of the internal

evaluation report.

14. When we do the site visit, with whom do you think we should visit?

15. In what format (individual meetings, focus-group discussions, other) should these meetings occur that will best facilitate information gathering and be least disruptive to your operations?

16. Please describe your payer mix and the degree to which you feel this mix impacts your ability to successfully initiate/maintain your EPCH Initiative?

17. Please describe any efforts to integrate behavioral health into your program?

    a. To what extent is it occurring?
    b. In what form is it occurring (screening, assessment, referral, treatment)?
    c. If screening, for which disorders are you screening?
    d. What are key challenges and concerns related to behavioral health integration?

18. Are you utilizing a "health teams" model in your program? If so, please describe the makeup of the team, challenges and successes you have experienced with this model?

19. To what extent is your EPCH implementation impacted by staff shortages? Are there specific staff training and/or recruitment needs?

20. Are there payment reforms or other state or local policy changes that could support implementation and expansion of EPCH efforts in Ohio?

21. In what ways could college or university programs support implementation and expansion of EPCH efforts in Ohio?

22. Please describe your geographic setting (rural, urban, suburban, Appalachian, etc.) and the degree to which you feel this mix impacts your ability to successfully initiate/maintain your EPCH Initiative?

23. Who are the key thought leaders in your site for the EPCH Initiative?

24. If you are an "emerging" EPCH site, please consider the practices that are weighing whether to adopt the EPCH model or participate in your efforts. What are the perceived benefits, perceived challenges, and cost-benefit ratio for participation? Do the perceived benefits outweigh the costs?

25. If you are an existing EPCH site, what types of changes have been required to implement the EPCH model? (Capital expenditures, policy, personnel) What are the costs associated with these changes (not dollar amounts, but relative estimate of the cost burden for things like staff time and other resources)?

26. Are there any issues we have not covered that you would like to make sure we address during the site visit, and is there anything else about your site/initiative that you would like us to know?

Questions for the Interview with TransforMED leadership:

27. Please consider the questions above that are asked of each of the sites. We will go through those questions and ask your perspective on each of them as an outside consultant, thinking about the experience of all

Ohio sites with which you are familiar.

28. What are some of the particular challenges and barriers to EPCH implementation for the state of Ohio that you perceive, given your experience of the EPCH implementation project in this state?

29. Is there anything that we have not covered that you think is important for us to know about EPCH implementation in the state of Ohio?

Questions for the Interview with OAFP leadership:

30. Please consider the questions above that are asked of each of the sites. We will go through those questions and ask your perspective on each of them as an outside consultant, thinking about the experience of all Ohio sites with which you are familiar.

31. What are some of the particular challenges and barriers to EPCH implementation for the state of Ohio that you perceive, given your experience of the EPCH implementation project in this state?

32. What are the successes and accomplishments from this initiative that will continue to contribute to the EPCH landscape in the state of Ohio over time?

33. What are the "lessons learned" for the state of Ohio from this initiative?

34. Is there anything that we have not covered that you think is important for us to know about EPCH implementation in the state of Ohio?

Appendix 2- Aggregated, De-Identified Interview Responses

Scope of Practice Engagement

Project leaders were asked to describe the number and types of practices with which they were engaged and the degree to which the practices were ready to transform to the Patient-Centered Medical Home (PCMH) model. Emerging projects reported 65 applicants for the 44 practices envisioned for the four emerging project regions. Project leaders also indicated that a practice selection process was underway and expected to be completed by early summer, 2011.

Existing projects reported between 11 and 48 practices engaged in practice transformation efforts, with varying degrees of progress toward NCQA certification. In Cincinnati, of 11 practices initially engaged, 7 practices have achieved NCQA Level 3 certification, 2 practices have achieved NCQA Level 2 certification, and 1 practice has achieved NCQA Level 1 certification. In addition to pilot practices, nine other practices wanted to join with no guarantee for PMPM payments from payers. Most of those additional practices have applied for NCQA certification and were successful at the level of certification for which they applied. In Columbus, practices are applying for NCQA certification with success, at various levels. Here, NCQA certification is considered the "starting point, not the finish line." Nine of the initial 27 practices have achieved NCQA certification at the level for which they applied, 18 others are in various stages of the application process, and the goal is that they will all have applied for NCQA certification by September, 2011. In Cleveland, 48 practices are engaged in this project designed to create support systems for PCMH-based quality improvement for safety net practices in northeast Ohio. Over 500 physicians in 48 practices, representing highly affluent health care delivery settings and highly underserved populations are participating, and these practices are in various stages of deciding whether to pursue NCQA certification.

Emerging EPCH sites suggested that NCQA certification should not be considered the ultimate measure of this initiative's success. Many practices in underserved areas, including small practices and those in rural areas, are hard-pressed to make the up-front technology investments for electronic health records, extra staff, and other up-front costs to meet NCQA standards. The implementation of electronic medical records and the coming payer push to adopt NCQA certification as a benchmark for added payment, or for avoidance of penalty, will drive all practices in this direction, but it should be noted that these are significant hurdles for small practices, those in areas with low penetration of technology interfaces (including high-speed internet access) and those serving disadvantaged populations.

Payer Engagement– Successes and Challenges

Interviewees described a number of successes and challenges in working with insurance payers as part of their projects. For the existing projects, this process was much more robust and developed, because those projects had been underway for some time. For emerging projects, their concerns and experiences to date are reported.

Successful strategies

- Use national data from evaluation of patient-centered medical home (PCMH) initiatives to make the "business case."
- Engage payers early in learning collaboratives and leadership groups.
- Identify biggest payers in the region and work with them early and often.
- Develop relationships with payers – don't make "cold calls."

- Getting all payers in the room together is a good first step – this is sometimes very hard to do.
- Consider developing an "employers symposium" and invite payer representatives – this is their market; help their buyers see the value for patients.
- Find some large employers or employer collaboratives that already exist and use their market presence to get payers in the room.
- Use data from Geisinger, North Carolina Medicaid, and recent publications to help make the business case.
- "They need to see that whatever you do is going to save them money."

Challenges and other observations

- Payers have supported a number of pilot projects and are ready to see actual, bottom-line results... Payment reform that mandates payer participation will be necessary.
- Successful payment reform MUST include:
  - PMPM fee for care management
  - Fee for service for routine care
  - Pay for performance component
- From payers' perspective, if payment reform is enacted, but practices are not required to participate, they are disadvantaged. It has to be a two-way street from their perspective.
- When payers and physicians in the room, a lot of feedback and frustration from physicians is often put forward.
- Support for payment at the federal level, including both Medicare and Medicaid, would support the implementation at the state level as well.

Outcome Measures – Planned and Active

EPCH project sites are in various stages of developing their outcome measures and planned evaluation. At least one project is deeply involved in measurement, including evaluation of cost using claims data. Most are awaiting direction from the statewide group planning for outcomes measurement for this initiative. Key observations from interviewees include the following:

- In the case of the existing projects many are working with TransforMED to manage evaluation.
- Some evaluation measures being developed are proprietary to the projects.
- Measures from AHRQ, specifically the Consumer Assessment of Health Care Providers and Systems (CAHPS) questions, and specifically questions from CAHPS designed to evaluate medical home sites, are under consideration.
- Some, but not all, are collecting data on burnout and team satisfaction. Where it is being collected, it is most often collected using the Maslach Burnout Inventory, as recommended by the statewide evaluation team.
- Some are using the Patient Activation Measure (PAM) to measure patient engagement with their care.
- Collection of cost and utilization data depends upon relationships with payers.
- Attainment of NCQA certification is a measure for many of the existing projects, but several projects caution that this is both "just one step," and that many practices are not even engaged with

electronic health records yet, so attainment of this goal is a long process.

- Other "measures of success" include
  - Access to same-day scheduling
  - HEDIS measures of quality
  - Hospitalization, rehospitalization, emergency room utilization and generic drug use
  - Measuring practice change and improvement over time
  - Outcomes measures for curriculum transformation in the emerging EPCH projects are an important consideration and these measures have not yet been developed
- Several leaders suggested that the experience of the patient, family and community as EPCH is implemented should be considered.
- "Going forward, rural practices are not as far along as larger system practices in terms of technology; there is a lot of momentum toward using NCQA criteria as the progress measure; some folks who don't lead on technology side are leading with regard to team-based learning and behavioral integration."

Key Successes and Best Practices

Each project was asked to describe its key successes in the EPCH Initiative. Key successes reported include:

- NCQA recognition was obtained for many practices, including recognition at the level applied for (see caveat above about the use of this measure as a primary benchmark).
- Hearing practice members talk about how hard it was, but that they would "never go back," and that they were "finally practicing medicine the way they always wanted to."
- Developing strategic partnerships within regions and across the state – this was felt to be hard to measure, but important.
- Getting multiple payers into the room to just talk was a success.
- Participation of safety net practices alongside other, more highly-resourced systems, and seeing those highly-resourced systems share their "best practices" and achievements were significant achievements.
- Watching those who have already done this help those who are interested in doing so was exciting.
- The team approach that EPCH puts forward is not just within the practice – it involves the way the project sites do business as well and has been a key success.
- Getting so many practices to apply (65) for the emerging project sites was a success.
- The statewide webinar about EPCH was very helpful.
- One project paid $4500 to practices to attend 4 two-hour seminars – this provided adequate compensation for time lost from the office; they did not keep attendance or time sheets.

Key Challenges

Each project leader was asked to describe challenges and barriers to implementation of EPCH efforts in their project. Key issues reported included:

- Getting payers to engage in meaningful payment structure modification to make this effort worthwhile to providers was important.
- Engaging practices to do continuing quality improvement (CQI) activities, given the time and need for record-keeping to sustain this, was a challenge.
- Sustainability of the effort is questioned given that there is no permanent payment reform structure in Ohio, and little funding clearly allocated to support ongoing transformation efforts.
- Allowing access to medical records for patients was a challenge.
- The mental health payment system makes it nearly impossible to achieve truly integrated behavioral health in this model.
- There is a significant degree of skepticism on the part of primary care providers that this model is a repetition of prior experiences they have seen with HMOs, in which primary care providers carry all the risk for implementation of the model, and share none of the reward. Respondent burden from requests for information (at the level of the practice and the provider) is a significant challenge to ongoing participation in this model.
- Lack of penetration of high-speed internet and other data connectivity in rural areas is a significant concern in terms of infrastructure for practices that are considering this model.
- Affordability of access to data for patients in both rural and urban underserved areas is a challenge to truly engaging patients in their care.
- If the federal government recognized this movement as contributing to the "triple aim" model, 12 and reimbursement at the federal level followed, the shift to this model would happen nationally.

Insight for Practices Considering Implementation of EPCH

Project leaders interviewed offered a number of insights to those considering implementation. Their suggestions include:

- Practice transformation has to be a transformation of culture in the practice that happens simultaneously with process change, such as meeting NCQA certification standards and conducting CQI activities.
- Cultural transformation has to actually "lay the groundwork" for the subsequent process change that is required.
- Achieving NCQA recognition alone is not sufficient and is not sustainable.
- Everyone in the practice must be motivated and dedicated to do the work.
- This effort is "not for the faint of heart," and "not for those who just want to see what it's all about."
- The practice must be open to new ideas and willing to ask for help; it is very difficult for practices to do this alone.
- Communication, leadership and teamwork are required.
- Having a clinician "champion" and an administrative "champion" is truly mandatory.
- To achieve transformation into the EPCH model, practices must select a good electronic health record (EHR) that is capable of data mining for the practice so they can perform robust CQI initiatives.
- Practices must have a good attitude, be motivated, and will need money to invest in the process in

order to succeed.

- There is no assurance yet that this model will result in value-based payments. This is still in pilot mode.
- Get an objective assessment from a consultant about where you are in the process of being ready to tackle these changes, but . . . Do not fall victim to a lot of consultants who are in the space trying to make a lot of money and take advantage of practices.
- Consider investing in care coordinators and other interprofessional team members – they are part of what makes this model really work.
- Appreciative inquiry techniques can be useful. An example question is, "What is needed in this practice for this model to be successful?"
- Communication is critical, from the front desk person through all the providers to the person who files the reports and works with the consultants. Everyone has to be able to communicate. Evaluate how you communicate BEFORE you begin.
- Be clear on your motives – doing this because you want to make more money is not enough, and is probably not a sustainable reason.
- A lot of things have happened with PCMH transformation practices across the country.
    - Better patient outcomes
    - Better physician satisfaction within the practice
    - Better office staff satisfaction
    - Better patient satisfaction because of increased access
    - Even where there is no payment reform, efficiencies have improved, so bottom line has improved, because expenses go down.
- If people take the steps, but don't see the outcome, it won't work.
- This process will change the way you work together as a team.
- "Look through things first to get your head around all of the different pieces. Pick a very small piece that you have a 95% chance of accomplishing over the next three months. If (members of the practice) know change theory, that's how you do it. Get everyone on board, give them a vision, and help them understand. If they bite off too big a piece, they will get discouraged and give up."
- "Perseverance matters – the tensions teach!"

Burnout and Staff Turnover

All existing EPCH project leaders expressed strong feelings that burnout could be a challenge in adoption of the model of practice transformation. Emerging project leaders expressed varying degrees of expectation that this would be the case. Key points of discussion included:

- One risk is taking on too much change, too fast. Providers are in the midst of trying to make a living, and other pressures beyond practice transformation are high.
- This phenomenon is related to the volume and pace of change, coupled with economic pressures.
- Some concern was expressed that the EPCH model is not sustainable without funding to support practices, because once it happens, the changes will become higher in volume and the stakes will

escalate as well.

- Burnout seems to be a particular risk for Federally Qualified Health Centers (FQHCs) in this process.
- Self-motivated practices (those who are really excited about the transformation process) have less difficulty, but it is still a lot of hard work, and that can contribute to burnout.
- Implementation of EHRs is not easy, and the rewards have not been fully realized in many places, even two years into the process. They do not make life easier on the front end.
- Having staff turnover was acknowledged as a potential problem, but had not been directly experienced by most project leaders as part of practice transformation.
- Most project leaders feel that the current economic situation makes the workforce for office staff fairly stable and eager to stay in place; however. However, note was made of the declining level of training for most practice staff over the last 15-20 years. Twenty years ago, most physicians worked with an RN and perhaps an LPN. Now most hire medical assistants, and it is rare to have the more advanced-trained members of the team, unless they are an advance practice nurse seeing patients themselves.
- Practices are concerned about having to hire more staff to implement this process – "there is a lot of anxiety out there."
- "I was taken aback by the level of physician frustration and anger that was voiced at our town hall meetings before the applications even began."

High-Volume Medicaid Practices

Project leaders were asked to describe the degree to which high-volume Medicaid practices were involved in their efforts, and any barrier, challenges or successes they had noted in helping these practices to achieve and successfully participate in practice transformation. Their reports include the following:

- It seems to be harder to have these practices implement EHR. Costs up front are high.
- Many practices who have been high-volume in the past are not accepting new Medicaid patients.
- Safety net practices tend to see more folks who are homeless and transient, and helping those practices meet quality benchmarks is a challenge. Those who are willing to put their numbers up against more-resourced practices in a learning collaborative environment are to be commended.
- If payment reform comes through Medicaid, it could provide an infusion of cash into these practices that they have not seen before, and that could help with implementation costs, but which comes first? Payment reform or implementation?

Payer Mix Among Practices

Project leaders were asked to describe the payer mix for the practices they serve. Many did not have this information directly and indicated it would need to come from the practices themselves. The mix varies by geographic and socioeconomic distribution, with some rural or urban practices being nearly exclusively Medicaid, and carrying high rates of uninsured patients. FQHCs are generally 30-50% uninsured, 40% Medicaid, 8-10% Medicare and commercial insurance.

Behavioral Health Integration

Project leaders were asked to describe the degree to which behavioral health was integrated into their sites, or was planned to be. Responses varied, but seemed to indicate that most were struggling with exactly how to do this, particularly given the difficulties with mental health reimbursement of non-physician providers and the multiple payers who provide mental health reimbursement. Some specific issues include:

- Where mental illness is being screened, most practices that do this are focusing on either depression or anxiety, or both.
- Few practices have robust integrated teams for behavioral health, but some are attempting to do this.
- Some project leaders made a distinction between behavioral health issues (mental illness) and health behavior issues (risky behaviors such as tobacco use, alcohol use, and others). Inclusion of health behavior issues as part of the behavioral health model would provide a venue for improving both physical and mental well-being and patient outcomes.
- Consideration might be given to developing a dial-in consultation service for primary care providers.
- Updating of telehealth regulations in the state could work to ease the provider shortage and maldistribution problems.
- Mental health provider workforce at the terminal degree level (PhD psychologists and physicians in psychiatry and child psychiatry) is sorely lacking, particularly in many rural and underserved areas.

Utilization of Health Care Teams

Project leaders were asked to discuss the degree to which "health care teams" had been implemented in their practice sites. Many indicated that early efforts were underway, but few sites had a fully-functioning, multidisciplinary or interprofessional health care team in place. Key issues discussed included:

- Many practices have one or two disciplines beyond medicine represented, but few have a fully-functional team that meets regularly.
- High-functioning teams have every member practicing at the top of the scope of their licensure at all times.
- Ideally, there should be two kinds of team meetings
    - o One to discuss complex patients and complex problems and to brainstorm about how to solve those problems and help those patients.
    - o The second should be a process-oriented meeting to discuss interpersonal and interprofessional issues as they arise for the team and to undertake team development work.
- If there is no highly functional team in place, it will take some time and effort.
- Teams must include front office staff, multiple professional staff and administrative staff, and all components of the practice in order to be a high-functioning team.
- Smaller practices and safety-net practices like the FQHCs may not have the resources to hire

interprofessional team members. Consideration should be given to an incentive structure and resource distribution that would support such practices and smaller practices may end up having to combine with others for economies of scale.

- A salient quote: "Team means understanding and recognizing and rewarding what everyone can do to take care of the patients and families coming into your practice."

College and University Involvement in EPCH Initiative

Project leaders were asked to describe ways in which Ohio colleges and universities could be helpful in supporting the widespread dissemination and implementation of the EPCH model. Their thoughts include:

- Curriculum transformation to expose learners in all health professions to the EPCH model early and often during their training is critical.
- Creating opportunities for interprofessional learning from role-model teams is also important.
- "Academics" need to be familiar with what a typical practice currently requires of its providers. It's easy to be unaware of current pressures if you are university-based.
- Recognize the cost to practices in terms of time and income if they accept students.
- Give those who are designing curriculum time to do it right. Curriculum reform is not "a hobby."
- Need to create incentives in the pipeline for those who choose primary care.
- The curriculum should highlight teamwork, care coordination and continuity of care, as well as interprofessional and patient-centered models.
- Do not forget that we will need to train those who are already out in practice about this model.
- It is possible to mandate such curriculum changes through accreditation processes.

Perceptions of Cost-Benefit to Engaging in EPCH Initiative

Project leaders were asked to give their best assessment of the cost/benefit analysis for practices participating in EPCH practice transformation. They were particularly asked to describe the biggest cost drivers that seemed to be problematic for practices. Their responses included:

- Personnel costs are a significant burden, particularly with turnover and burnout.
- EMR implementation is a high-cost, up-front burden. Federal monies may be shifting this, but it's too early to tell. Most primary care practices don't have the margin to be able to lay out the cash up front.
- Time is at a premium, and the energy and ability to devote time to this effort is a high cost, but hard to monetize.
- The opportunity cost of lost time in the practice while conducting practice transformation is also significant.
- "I think the benefits outweigh the costs."
    - o We know that we do better patient care out of this model. That's really what we are all about. If we did nothing else, that's what doctors should do.
    - o We know it improves patient satisfaction

- We know it improves job satisfaction among physicians and staff
- In the right setting (payment reform), this model increases bottom line to the practice, but... "Even if we didn't get paid a dime more, this model does everything else right."

- "From the rural exemplar, they had in fact reduced staffing, as you thought about your team all being counted, they were credited; efficiencies were gained with medical records. Not everyone required upfront expenditures."

Other Issues

Several additional issues rose during conversations with the EPCH project leaders. Those most relevant to implementation of the EPCH model in the state of Ohio include:

- This project should continue to have momentum under the new administration at the state level. It needs support for leadership, infrastructure and payer reimbursement.
- It is a pretty big sacrifice for all the meetings to be in Columbus. It takes all day out of the office, and the project specifically prohibits use of funds for travel or food.
- There is value to doing a statewide evaluation with good up-front communication about that process.
- Licensure and scope of licensure issues for advanced-practice nurses are different (more restrictive) in Ohio than almost any other state. This impacts the functioning of robust health care teams.

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