

## TASK FORCE FUNCTIONS

- **MISSION INTEGRATION**  
Transformation of clinical care, education, and outcomes research
- **INFORMATION CLEARINGHOUSE**  
Information distillation to ADFM membership
- **STRIKE FORCE**  
Proactive leadership to shape policy and influence change among key stakeholders

## Changes to the PCMH Taskforce

You might have noted in President Rich Wender's recent *"What's on Our Plate"* that the ADFM Board has approved a new governance structure including new strategic committees; one of these

new strategic committees, the Healthcare Delivery Transformation Committee, will replace and oversee the areas which our taskforce has been devoted to. More details on these changes will be forthcoming

through this newsletter, through more updates from President Rich Wender via our Chairs' and Administrators' list-serves, and at the ADFM Fall meeting in Denver, CO on Saturday AM, Nov. 5.

## Center for Medicare and Medicaid Innovation

The CMS Center for Medicare and Medicaid Innovation (CMMI) launched its new website on Monday, March 21. The site, <http://innovations.cms.gov> will serve as a main conduit for information and updates from the CMMI, as well as a forum for the submission of proposed projects and ideas. A key component of the site is the explanation of the Innovation Center's process for selecting potential models, as follows:

- Solicit ideas for new payment and service delivery models, through activities such as open door forums, listening sessions, and the CMMI website;
- Select and develop the most promising models;
- Test and evaluate models and;
- Expand and spread successful models.

In considering ideas for new models, CMMI will be relying on its Portfolio Criteria (available at <http://innovations.cms.gov/about-us/portfolio-criteria/>). No one model will address all criteria, but models should look to have the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries through identifying needs that are currently going unmet and addressing these areas. The application process will vary for each specific program, and announcements and application instructions will be posted on CMMI's website.

On Friday, July 8, HHS announced an opportunity through the CMMI for states to participate in a demonstration program testing two new financial models to provide higher quality and lower cost care to dual eligible beneficiaries:

- A capitated approach in which a state, CMS, and a health plan would enter into a three way contract where the managed care plan receives a prospective blended payment to provide comprehensive, coordinated care.
- A managed fee-for-service model wherein a state and CMS enter into an agreement under which the state would be eligible for a retrospective performance payment from savings from managed fee-for-service initiatives.

States that are interested in pursuing these models must submit a letter of intent to CMS by October 1, 2011. More detailed information is available in a fact sheet on the [CMS website](#).

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## Workforce Planning for Primary Care

### COGME 20th Report

The Council on Graduate Medical Education (COGME) recently released its 20th report, entitled “**Advancing Primary Care.**” (<http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf>) The report presents compelling evidence that health care outcomes and costs in the United States are strongly linked to the availability of primary care

physicians. Key factors that COGME believes contribute to a shortage of primary care physicians include the practice environment, the experiences of medical students, the system of graduate medical education, and physician mal-distribution. The council recommended that Congress and the Department of Health and Human Services (DHHS) implement policies that increase the percentage of

primary care doctors to 40 percent of the total number of U.S. physicians. In addition, it calls on medical schools and academic health centers to strategically focus and change the processes of medical student and resident selection, and alter the design of educational environments to foster a workforce that attains this goal.

*Ideas for future newsletters? Contact Libby Baxley at [libby.baxley@uscmed.sc.edu](mailto:libby.baxley@uscmed.sc.edu)*

### Ensuring an Effective Physician Workforce for America: Recommendations for an Accountable GME System

In February, a panel of leaders in academic medicine and health care urged Congress to seek an independent, external review of how U.S. graduate medical education programs are governed, financed, and regulated to make sure that they are producing the right number and mix of physicians and that they are more accountable to public need. The group called for an immediate, one-time increase in the number of residency slots in targeted specialties so the United States can maintain a ratio of 250 doctors for every 100,000 people. The recommendations

were part of a package of proposals for reforming GME policy that emerged from an October 2010 conference on the future of GME co-sponsored by the Josiah Macy Jr. Foundation and the Association of Academic Health Centers. The GME Policy Workgroup included 22 leaders in academic medicine and health care delivery, who heard testimony from six expert panelists representing organizations involved in the governance and financing of GME and reviewed four commissioned papers. The Policy Workgroup agreed with the recommendations from the

Council on Graduate Medical Education for a one-time increase of 3,000 entry level GME positions in specific disciplines to align specialty mix with societal need, which currently includes adult primary care physicians in family practice and general internal medicine; general surgeons; and psychiatrists. Specific recommendations can be found in conference summary at <http://josiahmacyfoundation.org/publications/publication/proceedings-ensuring-an-effective-physician-workforce-for-america>

## CMS Releases ACO Regulations

On March 31st, CMS released the proposed regulations for Medicare ACOs, with a comment period that closed on June 6th. Key features of the proposed regulations include:

- This is a voluntary program, beginning on January 1, 2012, and ACOs must sign up for three years; it prohibits programs from signing up for both ACO and Center for Medicare and Medicaid Innovation (CMMI) shared savings pilots.
- Registering ACOs must have a minimum of 5,000 Medicare beneficiaries who are served; beneficiary attribution is retrospective, based on claims data with a six-month run out period, and is determined based on a plurality of primary care services (E and M) for IM/FM/GP/Geriatrics. Beneficiaries can opt-out of participation. Unlike specialists, primary care providers can only belong to one ACO.
- Participants continue to receive fee-for-service payments, but also have the opportunity for receiving shared savings. Shared savings are based on meeting quality thresholds,

which included 65 proposed measures. In the first year of the program, ACOs will only need to report these measures to benefit from shared savings, but in years two and three they must meet specific thresholds to benefit financially. All 65 measures must be reported to trigger the shared savings.



- The program, originally intended to attract participation from physician groups, seems to target hospitals employing physicians, large physician group practices, networks of physicians and joint ventures. One potential reason for this is the capital investment required (estimated in the \$1.75-2 million range) to start an ACO. As an example, within the ACO, 50% of the primary care providers must be meaningful EHR users by year two.

- Historical benchmarks will be used for determining costs/expenditures, related to ACO-specific spending on Medicare Part A and B for the three most recent years, using historical beneficiaries
- Two pay-out plans were included – one that is an “upside,” no risk option only for the first year, and another “upside/downside,” higher reward/higher risk model. A minimum savings threshold is required before shared savings begin. Additional dollars are included for FQHCs and Rural Health Centers.

A number of responses were prepared to address concerns in the proposed regulations, including feedback and recommendations from the AAFP, CAFM, the PCPCC, and the AAMC. Final regulations have not yet been released.

The CAFM comments submitted by the requested June 6 deadline reside at the STFM Advocacy Briefing Room at [http://www.stfm.org/Final%20ACO%20joint%20comment%20letter%206%2011\(1\).pdf](http://www.stfm.org/Final%20ACO%20joint%20comment%20letter%206%2011(1).pdf)

From PCMH H2R Minutes on July 27, 2011:

### AHRQ offers new “Catalogue of Federal PCMH Activities”

AHRQ has debuted a “Catalogue of Federal PCMH Activities” on its patient centered medical home [website](#). The catalogue summarizes the PCMH-related work of departments and agencies participating in a federal PCMH collaborative; it includes overviews of each agency’s activities and a table comparing activities and collaborations across agencies. The website also contains AHRQ’s definition of the PCMH, white papers on care coordination and the medical neighborhood, briefs on health IT and patient engagement, and a searchable database of articles.

## Interprofessional Education in the Health Professions

### Core Competencies for Interprofessional Collaborative Practice and Team-Based Competencies: Building a Shared Foundation for Education and Clinical Practice

#### Access the reports here:

- 1) [Core competencies for Inter-professional Collaborative Practice](#)
- 2) [Team-Based Competencies: Building on a Shared Foundation for Education and Clinical Practice](#)

On May 10th, health educators released two new reports (see side bar) that recommend new competencies for interprofessional education in the health professions, and action strategies to implement them in institutions across the country.

Released by six national health professions associations (the AAMC, American Association of Colleges of Pharmacy, American Association of Colleges of Nursing, American Association

of Colleges of Osteopathic Medicine, American Dental Education Association, and Association of Schools of Public Health) and three private foundations (Josiah Macy Foundation, RWJ Foundation, and ABIM Foundation), the reports establish competencies that proponents believe will transform our nation's health care system to provide collaborative, high-quality, and cost-effective care to better serve every patient. These reports can be very helpful for ADFM

member departments who are leading or participating in curricular reform efforts focused on reducing educational silos and creating opportunities for collaborative training and practice across health professions schools.

In addition, the "Practice Transformation Guide" has been approved by the PCPCC Board and will be on their website in the near future.

## Additional PCMH Resources

### AHRQ PCMH Resource Center

The AHRQ Patient Centered Medical Home Resource Center ([http://pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483](http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483)) has two new publication that are worth reading: **Coordinating Care in the Medical Home: Critical Components and Available Mechanisms** (June 2011) and **The Role of PCMHs and ACOs in Coordinating Patient Care** (December 2010).

### Family Medicine Dedicated Issue on Education and the PCMH

Just out! The July/August issue of *Family Medicine* is a dedicated issue on residency redesign. A number of ADFM members are featured authors in this edition, which has a variety of articles describing educational innovations in family medicine residency programs. Another must read for our members:

<http://www.stfm.org/fmhub/toc.cfm?xmlFileName=fm2011/fammedvol43issue7.xml>

### The Medical Education Futures Study

The Medical Education Futures Study website has undergone recent renovation and has excellent resources that include publications, resources and a blog site related to examining medical education's role in reducing disparities, increasing access and improving health in an era of health care reform ([www.medicaleducationfutures.org](http://www.medicaleducationfutures.org)). The mission of MEFS is to highlight the social mission of medical education during the current period of medical school expansion and potential major health care reform. The website serves as a vehicle of information and data dissemination for the community of students, educators, practitioners, researchers, policy analysts, policy makers and press.

A recent issue of the MEFS Newsletter highlighted an opinion piece [A Recipe for Medical Schools to Produce Primary Care Physicians](#), Stephen R. Smith urges medical schools to implement policies that would encourage more students to enter primary care. Smith argues that in order to increase primary care graduates, medical schools should build curriculum around primary care principles, offer opportunities for students to complete clinical training in community settings, and alter admissions criteria to admit students more likely to pursue primary care.

# PCPCC UPDATES

## PCPCC Education and Training Task Force

The PCPCC Education and Training Task Force is up and running, with three primary goals:

- To enhance the ability of health professional schools and postgraduate training programs to select, support and train PCMH-ready clinicians
- To enhance the training of health professionals in interdisciplinary team-based care using a PCMH model
- To enhance the development of health professional faculty to be prepared to practice and teach PCMH principles

In early meetings, the Task Force members agreed that it will consider its work to be successful if more health professions schools are including PCMH training in their formalized curriculum; this training involves interdisciplinary teams of health professions students; an information repository is easily available for those developing curriculum/educational programs; and health professions faculty are more equipped and comfortable in teaching PCMH principles. Subsequently, a work plan was developed, and work groups were formed, to:

- Develop a PCPCC publication that reports on early adopters of educational innovation in PCMH training. This will serve as a resource for educators who are planning health professional curriculum that is focused on PCMH.
- Develop a webinar series that addresses some aspect of education and training for participating in PCMH. The first webinar, entitled “Workforce Training for PCMH – What are we doing to equip the team?,” was held in April, featuring ADFM’s own Jeff Borkan. This webinar is now posted to the PCPCC website and available for any who may have missed it: <http://www.pcpcc.net/webinar/taskforce-education-and-training-presentation-training-workforce-pcmh>
- Create an electronic resource link for curricular materials regarding PCMH; this will provide links through the PCPCC web site to existing electronic repositories that educators can access when planning curricular change, educational programs
- Create programming / links to programs that provide(s) faculty development around delivery system redesign and the education of health professionals re: PCMH; involve HRSA staff to integrate with their work in interdisciplinary education and training including best practices and resources

Family medicine educators are well represented in each of these work groups, as well as on the Task Force in general. A survey of Task Force members in May revealed that 32% were family medicine educators, while 10% were from internal medicine, 6% from pediatrics; 16% each from psychology/behavioral health; 10% nursing; 3% pharmacy and 6 percent undesignated. Learners represented by these educators include medical students, medical residents, psychology students (undergrad and graduate), nursing students (undergrad and graduate), PA students, pharmacy students, pharmacy residents, social work students. The majority of Task Force members are working in clinical primary care practice; 26% of these practices are recognized as PCMHs.

## PCPCC Center for Accountable Care

In March, the PCPCC launched its new Center for Accountable Care. The principal aim of the Center is to help ensure that a

strong, robust patient-centered primary care model is

at the foundation of accountable care organizations (ACOs) nationwide, and that programs and policies related to ACOs help maintain this focus. The Center will focus on identifying and making recommendations on regulations and policies to advance the success of ACOs with a strong PCMH foundation; identifying and sharing best practices around the establishment of PCMH-centered ACOs; and educating and advocating to multiple stakeholders (governors, other state officials, advocacy/consumer organizations, the media, federal officials) the policy recommendations of the Center. Amy Gibson,

COO of the PCPCC, is working closely with this new Center, and Mike Magill is representing ADFM on this Center's membership.

four working groups: Policies, Operations, Education & Advocacy, and Synergy & Coordination with other PCPCC activities. The CAC

has held several conference calls, especially to contribute to the PCPCC response to the draft Accountable

***Anyone may participate in Center for Accountable Care conference calls and webinars.***

Details of these are available at:

<http://www.pcpcc.net/master-schedule>

***Joint Principles for ACOs that served as basis for the PCPCC comments to CMS are available at:***

<http://www.pcpcc.net/content/joint-principles-accountable-care-organizations>

The Center for Accountable Care (CAC) of the PCPCC is co-chaired by:

- Blair Childs, Senior Vice President of Public Affairs for the Premier Healthcare Alliance,
- Ted Epperly, MD, Past President of the AAFP and Director, Family Medicine Residency of Idaho, Boise
- Dana Gelb Safran, ScD. Senior Vice President, Performance Measurement and Improvement Blue Cross Blue Shield Of Massachusetts
- Craig Sammitt, MD, President and CEO of Dean Health, Madison, Wisconsin

The CAC is organized into

Care Organization (ACO) regulations released by the Centers for Medicare and Medicaid Services. A major emphasis of the CAC is that ACOs should be founded on robust Patient Centered Medical Homes. Detailed preliminary ideas from the CAC in response to the draft ACO regulations are available at:

[http://gallery.mailchimp.com/dcfdd33cdd540f634734cf274/files/Health\\_Policy\\_Source\\_ACO\\_Table\\_of\\_Concerns\\_and\\_Items\\_of\\_Interest\\_1\\_.pdf?utm\\_source=Patient+Centered+Primary+Care+Collaborative+List&utm\\_campaign=a40d129340-Accountable+Care&utm\\_medium=email](http://gallery.mailchimp.com/dcfdd33cdd540f634734cf274/files/Health_Policy_Source_ACO_Table_of_Concerns_and_Items_of_Interest_1_.pdf?utm_source=Patient+Centered+Primary+Care+Collaborative+List&utm_campaign=a40d129340-Accountable+Care&utm_medium=email)

### **PCMH at Fall Academic Family Medicine Session at AAMC!**

The Academic Family Medicine Fall session, entitled "The Patient Centered Medical Home in Academic Health Centers: Can the Neighborhood be Built?" will feature indepth case examples of building PCMHs in AHCs from South Carolina and Massachusetts, followed by presentation of Graham Center data on value and cost savings of a PCMH in AHCs and comment from AAMC Director of Primary Care Affairs.

This session will be held on Sunday, November 6 from 10AM – 12Noon in Denver, Colorado (in conjunction with the AAMC annual meeting).

## PCPCC Meetings Update

On March 30th, the PCPCC held its annual stakeholder's meeting, entitled: A Foundation for Transformation and Reform. Elliot Fisher was the conference keynote, speaking on Primary Care: A Foundation for Transformation.

Major themes of this conference included:

- *Care Coordination and Federal Programs: Putting Structures in Place* – this panel discussed the latest developments in care coordination in federal programs, including new research from AHRQ, as well as how care coordination is being embedded in Center for Medicare & Medicaid Innovation pilots and medication-management programs
- *Benefit Plan Designs That Transform: Employer Engagement* - This panel included a presentation of the new white paper on PCMH metrics for employers, the business value of health and an employer's approach to blending value-based benefits with medical homes.
- *Breaking New Ground: New Center Focused on Accountable Care* - this panel introduced the new PCPCC Center on ACOs, and discussed the clinicians' perspective on PCMH-centered ACOs, a model of ACO implementation from a health plan and an overview of CMS draft regulations on ACOs.
- *Engaging Consumers: What's Working on the Ground* - this panel discussed findings from a recent survey

of PCMH pilots on best practices in consumer engagement as well as two models of engaging consumers to improve both individual health and health care systems

- *Practice Transformation: New Tools For The Trade* - an overview of new PCPCC resources aimed at helping primary care clinicians embark on the PCMH transformation process. Two practices provided an in-depth look at how they became patient-centered medical homes.

The Powerpoint Presentations in .pdf format for the March 30th PCPCC Stakeholder's Meeting are available online: <http://www.pcpcc.net/event/meeting/3-30-2011>

On Friday, October 21st, 2011, the PCPCC Annual Summit will be held in Washington, D.C. The theme for this year's Summit is: **"Five Years Making Healthy Connections: Collaborating to improve Care in the PCMH."** Panel topics will include:

- Workforce Training and Education in the PCMH
- Outcomes of the PCMH: A closer look at the data on quality and cost
- Purchases and Payers in the ACO Landscape
- Integrating Behavioral Health into the PCMH
- Team-based Care in the PCMH



### Five Years Making Healthy Connections: Collaborating to Improve Care in the PCMH

October 21, 2011 • 8 a.m. to 4:30 p.m.

Ronald Reagan Building | International Trade Center  
1300 Pennsylvania Avenue, NW | Washington, DC 20004



Registration is open for this meeting, and a more detailed agenda can be found at: <http://www.pcpcc.net/event/summit/10-21-2011/registration>. Registration fees will be waived for government employees. An additional 25 scholarships/tuition waivers are available on a first-come, first-serve basis for those who complete a brief request.

## PCPCC Resources

In March, Patient-Centered Primary Care Collaborative, in partnership with The Commonwealth Fund and the Dartmouth Institute for Health Policy and Clinical Practice has released **Better to Best: Value-Driving Elements of the PCMH and ACO**. This document represents a powerful demonstration of solidarity among thought leaders from health plans, physicians, academics, employers, federal payers and consumers on how to make the medical home and ACO support better care for individuals; foster better health for the community; and help reduce or control costs. Core areas of consensus illuminated in the report:

- The goals of both the medical home and accountable care organization are better care, better health and lower costs.
- Improvement must be considered both in terms of lower costs and value to the consumer of care.
- There is a critical role and need for ongoing reportable measurements that address these goals.
- Payment systems need to change and a range of payment models should be tested.

- Learning collaboratives and rapid learning environments are needed to establish an evaluation framework around these issues.

This is a must read for ADFM members who are working at the system level to help their institutions transform health care. A copy of the report is available for download at [http://www.pcpcc.net/guide/better\\_to\\_best](http://www.pcpcc.net/guide/better_to_best)

Another PCPCC white paper, entitled **Patient Centered Medical Home: Performance Metrics for Employers** (downloadable at <http://www.pcpcc.net/guide/metrics-for-employers>), comes from the Center on Employer Engagement. It offers suggested metrics for evaluating the impact of the PCMH on workforce health and productivity, based on existing literature as well as a series of case studies that are included in the white paper. In broad overview, the metrics and sources are noted in the table on the next page.

Several case studies are included in the report, a few of which have outcomes data. Only two of the case studies are tracking presenteeism (the phenomenon

whereby personal or family member issues impair work performance), even though studies suggest this may be the single largest cost to employers whose workers are not as healthy as they might be. The authors claim that existing studies suggest that the potential savings generated by a PCMH model for employees and their family members can show reduction in healthcare costs on the order of 25%, but that the gains from reductions in absenteeism and presenteeism may have a value that is twice or three times the value of the medical spend savings.

This white paper is critical for those who are in or contemplating direct contracting with self-insured employers for provision of clinical services, and can shine a light on current blind spots in value based insurance design. There are obvious opportunities for academic family medicine to participate as providers and, importantly, as evaluators of the impact of various approaches to improving workforce health. It suggests the importance of partnering with experts in how to investigate workforce health's impact on productivity and revenues.



**Metric and Data Source from PCPCC white paper "Patient-Centered Medical Homes: Performance Metrics for Employers"**

Metric	Data Source
Population health profile	Health risk assessment and medical claims
Healthcare utilization	Medical /pharmacy claims
Healthcare costs	Medical/pharmacy claims
Clinical measures and outcomes	Lab test results, clinician office measurements
Productivity – absenteeism	Absence tracking or payroll
Productivity – presenteeism	Self-reported employee surveys
Total health and productivity costs	Aggregate of healthcare costs and lost productivity value
Patient satisfaction	Clinician office or third-party originated survey (CAHPS)
Patient engagement in self-care (activation)	Clinician office or third-party originated survey (self-reported)