NH Multi-Stakeholder Medical Home Pilot

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NH Multi-Stakeholder Medical Home Pilot

Project Overview

In New Hampshire, we are uniquely positioned to design and implement a reimbursement system that values, prescribes and rewards medical care that is tightly coordinated and of superior quality and efficiency. Our ability to affect change is unique as we are comprised of stakeholders representing private and public payers, clinicians, delivery systems, state government and private citizens, and we have established positive precedents for advancing policy and programs through our work for and as the NH Citizens Health Initiative.

We value the primary care medical home as the standard for quality going forward in this 21st Century. The medical home is a community-based primary care setting which provides and coordinates high quality – planned, family centered health promotion and chronic condition management. It is positioned at the intersection of the health care continuum (vertical axis) and the continuum of community agencies and services (horizontal axis). The medical home is therefore uniquely positioned to draw more value from all aspects of health and community service systems. It is here where relationship centered, continuous and coordinated care is most needed. We seek to incent/reward care processes consistent with the medical home model (as endorsed by the AAP, AAFP, ACP and AOP). It is in this way that we intend to ensure that favorable health and cost outcomes are attained.

The NH Multi-Stakeholder Medical Home Project was initiated in January of 2008 as a joint effort of all NH Payers and representatives of the clinical communities. The pilot will commence on 01/01/2009 and payment will commence on 06/01/2009 and will run for a period of 24 months. It is our desire and intent to offer uniformity in patient attribution, reimbursement, technical support and outcomes measurement to deliver the greatest effectiveness possible in program design.
NH Multi-Stakeholder Medical Home Pilot
Memorandum of Agreement - Payer

As a Health Plan doing business in New Hampshire, we agree to participate with the NH Citizens Health Initiative (NHCHI) in statewide collaborative efforts to reduce costs and improve the quality of health care by agreeing to the following for the New Hampshire Multi-Payer Medical Home Pilot:

1) Agree, in substance, to the concepts outlined in the AAFP, AAP, ACP, AOA Joint Principles of the Patient-Centered Medical Home – February 2007 document, including the principles, enhanced access and payment sections.

2) Agree to cover a reasonable number of member lives for the pilot, final number to be determined and approved at a later date by participating Health Plans.

3) Agree to support the New Hampshire Multi-Stakeholder Medical Home Pilot to the extent it does not supersede existing Patient-Centered Medical Home programs that are already in existence as of the effective date of this pilot.

4) Agree to a common set of criteria to determine what constitutes a “medical home” for physician entry into the pilot, qualification for payment, and any bonuses offered to the extent feasible.

5) Agree to use a common evaluator for this pilot, to be selected and approved at a later date by participating Health Plans, and to submit claims and eligibility data in order to calculate program impacts on quality of care, service use, and cost.

6) Agree to a consistent approach for support services for the practices.

7) Agree to adhere to all applicable federal and state legal and regulatory requirements.

8) The parties recognize the importance and the potential benefits of the Multi-Payer Medical Home Pilot to the health and well being of the community and are committed to testing the medical home through the specified length of the pilot. However, the parties and their affiliates reserve the right to withdraw participation from the Multi-Payer Medical Home Pilot at any time if full agreement with the intent, design and goals cannot be reached unanimously by the participating parties.
New Hampshire Citizen’s Health Initiative - Multi Payer Medical Home Pilot
Memorandum of Agreement

As a family medicine, general internal medicine or independent advanced registered nurse practitioner group doing business in New Hampshire, we agree to participate fully with activities of the Citizen’s Health Initiative Multi Payer Medical Home Pilot. Participation in this pilot will help to demonstrate that comprehensive, coordinated care in a primary care Medical Home improves overall quality - and that longitudinal, patient and family centered care will simultaneously contribute to cost containment.

Should we be chosen as a pilot site we agree to the following statements and actions:
1) To promote and endorse each of the concepts, principles, and statements about access and payment outlined in the AAFP, AAP, ACP and AOA Joint Principles of the Patient Centered Medical Home – February 2007 (see enclosed).
2) To participate for the entirety of the pilot (which includes a six month pre-pilot “ramp up” preparation phase and for a subsequent 2 year period with payment and data collection.
3) To prepare for, apply, and pass the National Committee for Quality Assurance (NCQA) Medical Home Recognition at (minimum of ) Level 1 no later than June 1, 2009 by using the Physician Practice Connections Patient Centered Medical Home recognition tool (PPC-PCMH). See (http://www.ncqa.org/tabid/631/Default.aspx) for associated fees and application details guiding your application to achieve recognition.
4) To hold the plans accountable during Year 1 only for the determined level of reimbursement set for our practice at the onset of the pilot. Should our practice seek higher NCQA Levels of achievement at any time during the pilot we agree to inform the health plans 30-60 days prior to the onset of Year 2, at which time we will only be eligible for and request and adjustment in our PMPM which is applicable for Year 2 only.
5) To collect and report data according to requirements that will be developed in alignment with preexisting NCQA requirements and are consistent with other medical home demonstration efforts. The NHCHI pilot will facilitate consistency across plans and practices in elements required for program evaluation.
6) To use a HIPAA compliant population registry method and a HIPAA compliant communication process or tool with our patients, other providers, health plans and hospitals.
7) To sign a PCMH contract addendum with each private carrier/plan detailing the Medical Home per member per month payment and claims process for each health plan (CIGNA, Harvard Pilgrim, and Anthem).

_____________________________  ________________________________
Practice Owner/Manager        Practice Name / Date
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Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care plan to be responsive in any way for commercial purposes.

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NH Multi-Stakeholder Medical Home Pilot

Planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

*Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

*Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

**Background of the Medical Home Concept**

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

**For More Information:**

American Academy of Family Physicians
http://www.futurefamilymed.org

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
http://www.acponline.org/advocacy/?hp

American Osteopathic Association
http://www.osteopathic.org
## PPC-PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Access and Communication</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Has written standards for patient access and patient communication**</td>
<td>4</td>
</tr>
<tr>
<td>B. Uses data to show it meets its standards for patient access and communication**</td>
<td>5</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 2: Patient Tracking and Registry Functions</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses data system for basic patient information (mostly non-clinical data)</td>
<td>2</td>
</tr>
<tr>
<td>B. Has clinical data system with clinical data in searchable data fields</td>
<td>3</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>3</td>
</tr>
<tr>
<td>D. Uses paper or electronic-based charting tools to organize clinical information**</td>
<td>6</td>
</tr>
<tr>
<td>E. Uses data to identify important diagnoses and conditions in practice**</td>
<td>4</td>
</tr>
<tr>
<td>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</td>
<td>3</td>
</tr>
<tr>
<td>G. Tracks tests and identifies abnormal results systematically**</td>
<td>6</td>
</tr>
<tr>
<td>H. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 3: Care Management</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Adopts and implements evidence-based guidelines for three conditions **</td>
<td>3</td>
</tr>
<tr>
<td>B. Generates reminders about preventive services for clinicians</td>
<td>4</td>
</tr>
<tr>
<td>C. Uses non-physician staff to manage patient care</td>
<td>5</td>
</tr>
<tr>
<td>D. Conducts care management, including care plans, assessing progress, addressing barriers</td>
<td>5</td>
</tr>
<tr>
<td>E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities</td>
<td>20</td>
</tr>
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<thead>
<tr>
<th>Standard 4: Patient Self-Management Support</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Assesses language preference and other communication barriers</td>
<td>4</td>
</tr>
<tr>
<td>B. Actively supports patient self-management**</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 5: Electronic Prescribing</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses electronic system to write prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>B. Has electronic prescription writer with safety checks</td>
<td>3</td>
</tr>
<tr>
<td>C. Has electronic prescription writer with cost checks</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 6: Test Tracking</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks tests and identifies abnormal results systematically**</td>
<td>7</td>
</tr>
<tr>
<td>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 7: Referral Tracking</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks referrals using paper-based or electronic system**</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 8: Performance Reporting and Improvement</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measures clinical and/or service performance by physician or across the practice**</td>
<td>3</td>
</tr>
<tr>
<td>B. Survey of patients’ care experience</td>
<td>3</td>
</tr>
<tr>
<td>C. Reports performance across the practice or by physician **</td>
<td>3</td>
</tr>
<tr>
<td>D. Sets goals and takes action to improve performance</td>
<td>3</td>
</tr>
<tr>
<td>E. Produces reports using standardized measures electronically to external entities</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 9: Advanced Electronic Communications</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Availability of Interactive Website</td>
<td>1</td>
</tr>
<tr>
<td>B. Electronic Patient Identification</td>
<td>2</td>
</tr>
<tr>
<td>C. Electronic Care Management Support</td>
<td>1</td>
</tr>
</tbody>
</table>

** Must Pass Elements
## PPC-PCMH Scoring

<table>
<thead>
<tr>
<th>Level of Qualifying</th>
<th>Points</th>
<th>Must Pass Elements at 50% Performance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>75 - 100</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 2</td>
<td>50 – 74</td>
<td>10 of 10</td>
</tr>
<tr>
<td>Level 1</td>
<td>25 – 49</td>
<td>5 of 10</td>
</tr>
<tr>
<td>Not Recognized</td>
<td>0 – 24</td>
<td>&lt; 5</td>
</tr>
</tbody>
</table>

**Levels:** If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements are not Recognized.
Patient Attribution

United Healthcare Recommended Attribution Model

There are several options for member/PCP attachment.

- **Member selects PCP at enrollment.** High degree of accuracy; readily available.
- **PCP attribution derived.** Moderate degree of accuracy. Retrospective analysis required. Recognizes nuances of open-access plan designs.
- **Member and/or PCP signaling at pilot start.** Highest degree of accuracy. Requires the most resources & time to define.

Recommendation of the NH Multi-Stakeholder Group: PCP Attribution Derived

Attribution may be run once every six months, in May and December. There will be no monthly updates or reconciliation processes. The count will be for adult members only, used for the purposes of payment, and may not change within the six month period. Since the attribution process relies on claims data, we understand that a portion of patients who never present to the practice may not be counted until such time as they present and are included in the next period’s claims extract. Additionally, patients may be assigned to a particular provider, however it is known that patients may be seen at times by other providers including mid-levels and therefore any payments that are made after attribution may be paid to the practice or group as a whole and not to individual providers. Further:

- OBGYNs, Midwives and PA’s are not eligible,
- PA’s bill under the MD, so their services will be captured through the claims process,
- Certified Nurse Practitioners and MD's must be credentialed as PCPs with Anthem by 5/1 to be paid,
- Providers must practice at least 50% of their scheduled time at the pilot site to be considered part of the practice (this recognizes that the practice may have part-time providers, but 50% of their time must be at the site to be considered),
- Medical, and if possible, pharmacy claims will be pulled for an 18 month period for the providers listed by the practices,
- The members from those claims will be tied to the providers,
NH Multi-Stakeholder Medical Home Pilot

- If there is more than one visit in that period for a particular member, the latest visit will be used to tie the member to a provider.
- If two visits for a member occur on the same day, the visit with the higher dollar amount will be used to tie the member to the provider.
- The count of unique patients will be used for the per member per month calculation.
PCPCC Recommended Reimbursement Model

The most effective way to re-align payment incentives to support the PCMH would be to combine traditional fee-for-service for office visits with a three part model that includes:

- **A monthly care coordination payment** (“bundled care coordination fee”) for the physician work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes. Bundling of services into a monthly fee removes volume-based incentives and promotes efficiency. The prospective nature of the payment recognizes the up-front costs to maintain the required level of care. Care coordination payments should be risk-adjusted to ensure that there are no inherent incentives to avoid the treatment of the more complex, costly patients.

- **A visit-based fee-for-service component that** recognizes visit-based services that are currently paid under the present fee-for-service payment system and maintains an incentive for the physician to see the patient in an office-visit when appropriate.

- **A performance-based component that** recognizes achievement of quality and efficiency goals.

NH Multi-Stakeholder Group Recommendation

- The Care Coordination payment mid-point recommendation is $4 PMPM. This payment should be tiered according to NCQA PCMH Recognition Level. Payment will be made semi-annually, on a prospective basis, by each participating carrier, based on their membership.
- FFS payments that include payment for care plan oversight.
- Pay for performance payments from the carriers’ existing performance-based programs.
Medical Home Model Evaluation – Proposed and Pending Selection of an Evaluator

Primary Evaluation Questions
- If payers and providers make the investment in patient-centered medical homes, can it create value (as defined by cost savings or higher quality of care)?
- Will there be sufficient value created to cover costs of investment?
- What are the metrics that are best correlated to value creation?

Possible Secondary Evaluation Questions
- Is there a dose-response (better outcomes with higher levels of Medical Home)?
- Are there specific elements of PCMH that are better correlated with outcomes?
- How did practices transform?

Evaluation Methods
- Qualitative and descriptive. Best suited for process improvement, and sharing lessons learned regarding infrastructure issues, support teams etc...
- Quantitative. Quasi-experimental design involving simple pre-post comparisons, contemporaneous controls and interrupted time series. Metrics include: cost, quality (structural efficiency measures and process), patient experience, and provider satisfaction.

Cost Outcomes
- Standard utilization metrics
  - Avoidable in-patient stays
  - ED utilization
  - Office visits (specialty, primary care)
  - Pharmacy
  - Outpatient procedures and diagnostics
- Total cost
- Should include risk adjustment
Quality Outcomes Metrics

- CMS Group Practice Demo Metrics

### Diabetes

<table>
<thead>
<tr>
<th>Claims Based</th>
<th>Chart/Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb-A1c tests</td>
<td>HgbA1c ≤ 9.0%</td>
</tr>
<tr>
<td>LDL test</td>
<td>BP &lt; 140/90</td>
</tr>
<tr>
<td>Microalbumin testing or Dx/Tx for nephropathy</td>
<td>LDL &lt; 130</td>
</tr>
<tr>
<td>Retinal exam by MD/OD:</td>
<td>Complete foot exam documented</td>
</tr>
<tr>
<td>• 1 year/high risk,</td>
<td></td>
</tr>
<tr>
<td>• 2 years/low risk</td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal vaccine</td>
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</tbody>
</table>

### Coronary Artery Disease

<table>
<thead>
<tr>
<th>Claims Based</th>
<th>Chart/Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid Profile</td>
<td>LDL &lt; 130</td>
</tr>
<tr>
<td></td>
<td>Antiplatelet Rx</td>
</tr>
<tr>
<td></td>
<td>Lipid Rx</td>
</tr>
<tr>
<td></td>
<td>History of MI, on β-blockers</td>
</tr>
<tr>
<td></td>
<td>BP @ last visit</td>
</tr>
<tr>
<td></td>
<td>DM &amp;/or LVSD on ACEI</td>
</tr>
</tbody>
</table>

### Heart Failure

<table>
<thead>
<tr>
<th>Claims Based</th>
<th>Chart/Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV-EF in same year if hospitalized for HF</td>
<td>Qualitative/quantitative LVF Assessment</td>
</tr>
<tr>
<td></td>
<td>Visits weight documented</td>
</tr>
<tr>
<td></td>
<td>Visits BP documented</td>
</tr>
<tr>
<td></td>
<td>HF Education documented in last 6 months</td>
</tr>
<tr>
<td></td>
<td>LVSD on β-blocker</td>
</tr>
<tr>
<td></td>
<td>LVSD on ACEI</td>
</tr>
<tr>
<td></td>
<td>HF/AF on Warfarin</td>
</tr>
</tbody>
</table>
Preventive Measures

<table>
<thead>
<tr>
<th>Claims Based</th>
<th>Chart/Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-69 y.o. w/ mammogram in current or prior year</td>
<td>“Screened” for colon Cancer</td>
</tr>
<tr>
<td>Visits BP documented</td>
<td></td>
</tr>
<tr>
<td>Last BP&lt;140/90</td>
<td>If BP is &gt;140/&gt;90  → documented plan of care</td>
</tr>
</tbody>
</table>

Recommended Pay for Performance Measures

- Use PQRI (up to 4% additional Medicare payment)
  - Electronic prescribing
  - Chronic care management
  - Diabetes: HgbA1c Control, LDL Control, BP Control, Dilated Eye Exam, Urine Microalbumin
  - CHF: ACEI/ARB, betablocker
  - Asthma: pharmacologic therapy
  - CAD: antiplatelet therapy, betablocker post MI, ASA post MI
  - Care coordination: Medication reconciliation
  - Prevention
  - Flu vaccine
  - Pneumovax

Infrastructure Outcomes

- Assessing Level of Medical Home
- Should follow a pre-post design
- Purpose is to validate practice transformation and determine what makes a difference
  - Instruments:
    - Medical Home Index
    - Starfield survey
    - Primary Care Assessment Survey (PCAS)
    - TransforMed
Other Outcomes Domains

- Patient perspective:
  - PCAS (based on CG-CAHPS)

- Practice culture, teamwork, staff satisfaction:
  - Assessing the culture of Medical Group Practice (Krelewski)
  - Practice staff Questionnaire (PSQ) (Stange, Crabtree, et al)
  - Microsystems Assessment Tool (Nutting)
  - Leadership capacity (MHIQ subsection)
  - Community Linkages section of Assessing Chronic Illness survey (Wagner)
Pilot Participant Selection Criteria

Whereas the pilot project will be comprised of no fewer than 5 and no greater than 15 practices, representing a target of 30,000 patients, participants were vetted against the following criteria for a best-fit selection:

**Geographic & Ownership Diversity**

Overall pilot group composition must represent a mix of independent, hospital-owned, FQHC, FQHC look-alike and ARNP-run practices from all areas of the state (North Country, Mid-State, Monadnock Region, Southern NH, Seacoast). Clinicians should be a balanced mixture of general practitioners, family practitioners, and internists.

**Demonstrated Medical Home Readiness**

Practices must demonstrate a patient-centeredness and have implemented processes that, at a minimum, are consistent with must-pass elements outlined in the NCQA PPC-PCMH standards.

Practices must be able to attain a minimum of NCQA Level 1 recognition by 6/01/2009.

**Organizational Commitment**

The organization to which the clinic, practice, ARNP or physician belongs must be committed to the pilot, for its pre-implementation period and subsequent 24 month project duration. They must be further willing to participate in a pilot users group and receive and incorporate technical supports provided by the project.

Organizational commitment will be demonstrated through individual and executive-level signatures to a participant Memorandum of Agreement (MOA).
Dear Primary Care Colleague,

We are pleased to inform you that you have been accepted as a participating practice in the first New Hampshire Citizens Health Initiative - Multi-Stakeholder Patient-Centered Medical Home Pilot. This pilot represents collaboration among the NH Citizens Health Initiative (NHCHI) medical home workgroup, the Center for Medical Home Improvement, and the three private New Hampshire Health Plans: Harvard Pilgrim Health Care, CIGNA and Anthem, as well as NH Medicaid.

Pilot participants were selected based on their overall quantitative score, with consideration of their essay responses, organization type, geography and patient panel size. The selected pilot participants were the highest scoring applicants, yet also happen to represent the full spectrum of practice types and sizes, with geographic distribution that covers nearly the entire state. The practices selected, listed in alphabetical order, are as follows:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>City/Town</th>
<th>Practice Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ammonoosuc Community Health Services</td>
<td>Littleton</td>
<td>Health Center</td>
</tr>
<tr>
<td>Cheshire Medical Center Dartmouth Hitchcock</td>
<td>Keene</td>
<td>Keene Ind Multi-Specialty Practice</td>
</tr>
<tr>
<td>Concord Hospital Family Health Center</td>
<td>Concord</td>
<td>Hospital Owned Practice COOS</td>
</tr>
<tr>
<td>County Family Health Services</td>
<td>Berlin</td>
<td>Health Center</td>
</tr>
<tr>
<td>Derry Medical Center</td>
<td>Derry</td>
<td>Independent Physician Practice</td>
</tr>
<tr>
<td>Elliot Family Medicine at Bedford Commons</td>
<td>Bedford</td>
<td>Hospital Owned Practice</td>
</tr>
<tr>
<td>Lamprey Health Care</td>
<td>Newmarket</td>
<td>Health Center</td>
</tr>
<tr>
<td>Life Long Care</td>
<td>New London</td>
<td>Independent ARNP Practice</td>
</tr>
<tr>
<td>Manchester Community Health Center</td>
<td>Manchester</td>
<td>Health Center</td>
</tr>
<tr>
<td>Mid-State Health Center</td>
<td>Plymouth</td>
<td>Health Center</td>
</tr>
<tr>
<td>Westside Healthcare</td>
<td>Franklin</td>
<td>Hospital Owned Practice</td>
</tr>
</tbody>
</table>

The pilot will run for a period of two years, with an earliest payment start date of 06/01/2009. Pilot participants will be required to meet Level One NCQA PPC-PCMH Recognition by 06/01/2009 to remain in the pilot.

Our intent is to provide an ongoing forum for operational linkages with the health plans, as well as provide for opportunities for collaboration and sharing of best practices, both administrative and clinical.

Regards,

Edgar Helms,
Director, NHIHPP
**Medical Home Project Team**  
2009 Meeting Calendar for Pilot Participants  
4th Tuesday of Each Month at 8:00am unless otherwise noted  
All meetings will include a call in and web conference number for remote participation

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Location</th>
<th>Time(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 27th</td>
<td>Tuesday</td>
<td>CIGNA Offices</td>
<td>8:30 am to 12:00 pm</td>
</tr>
<tr>
<td>February 24th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>March 24th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>April 28th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>May 26th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>June 23rd</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>July 28th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>August 25th</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>September 22nd</td>
<td>Tuesday</td>
<td>NHCHI Offices</td>
<td>8:00 am to 9:30 am</td>
</tr>
<tr>
<td>October 27th</td>
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</tr>
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Operations Policies