Transforming Clinical Practice to Care for the Underserved: Community Health Centers and Patient Centered Medical Homes

Washington, DC | April 11, 2016

Summary of Proceedings
About PCPCC

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is a not-for-profit membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. The PCPCC’s mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care and achieve the “Quadruple Aim”: better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

The PCPCC is and will position itself as an advocacy organization—a coalition that serves as a “driver of change,” educating and advocating for ideas, concepts, policies, and programs that advance the goals of high-performing primary care as the foundation of our health care system. We achieve this goal by:

Disseminating results and outcomes from advanced primary care and medical home initiatives, and clearly communicating their impact on patient experience, quality of care, population health and health care costs.

Educating stakeholders and advocating for public policy that advances and builds support for primary care and the medical home, including payment reform, patient engagement, and employer benefit initiatives.

Convening health care experts, patients and thought leaders in the private and public sectors to promote learning, awareness, and innovation of the medical home model.

About CareFirst

In its 79th year of service, CareFirst BlueCross BlueShield (CareFirst), an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit health care company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.2 million individuals and groups in Maryland, the District of Columbia and Northern Virginia. In 2016, CareFirst invested nearly $44 million to improve overall health and increase the accessibility, affordability, safety and quality of health care throughout its market areas. The company employs approximately 5,000 associates and contractors in Maryland, Washington, D.C. and Northern Virginia.

CareFirst’s Mission

In accordance with the Charter of the non-profit health service plan, the mission of CareFirst is to:

- Provide affordable and accessible health insurance to the plan’s insured and those persons insured or issued health benefit plans by affiliates of subsidiaries of the plan.
- Assist and support public and private health care initiatives for individuals without health insurance.
- Promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health system operates.
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Executive Summary

The community health center1 (CHC) movement began in the early 1960s when two “neighborhood health centers” sought to provide care to the medically underserved living in the inner city and rural areas. Today, CHCs provide much-needed primary care services to over 25 million people in over 9,000 communities nationwide, regardless of ability to pay.2

Given their critical role in providing access to care, CHCs have been at the forefront of the rapidly-changing primary care landscape over the last decade. One important innovation has been the patient-centered medical home (PCMH) model. Through comprehensive, coordinated, and patient-centered care, the PCMH aims to achieve the Triple Aim of improved quality and outcome, better patient experience, and reduced spending.

By targeting primary care, PCMH programs throughout the U.S. yielded promising early results. In 2015, 58 percent of health centers had at least one site recognized as a PCMH, and research suggests that patients receiving care at federally qualified health centers implementing medical homes cost 41 percent less than patients receiving care at other sources. CareFirst, the largest not-for-profit Blue Cross Blue Shield health plan in the Mid-Atlantic region, operates the first and largest PCMH program, which transforms the delivery of care for more than 1 million members and 90 percent of the primary care providers in the region. The company’s PCMH program produced significant health savings for its members after resources and focus shifted toward high-quality and coordinated care. Overall quality of care, measured by the number of hospital readmissions and average lengths of stay, also improved.

Recognizing the important role safety net health centers play in serving the most vulnerable and chronically ill individuals, CareFirst believed that safety net health centers could use a similar approach to better achieve their goals with more support and resources. In 2012, the insurer launched a four-year investment to start the Safety Net Health Center Program Grant, which funded $7.1 million to 11 health centers, serving more than 68,000 underserved

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1 In most instances, the terms “community health centers”, “safety net health centers”, and “Federally qualified health centers (FQHCs)” are interchangeable, and refer to non-profit, community-directed, health care providers serving low income and medically underserved communities. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement.

individuals in Maryland, Northern Virginia, and Washington D.C. To ensure success, the initiative focused on seven key areas during its implementation:

- Practice transformation;
- Sustainable infrastructure;
- Enduring PCMH culture;
- Expansion of services;
- Capacity building;
- Establishment of Learning Communities; and
- Internal Partnerships

**Progress in the PCMH Movement**

On April 11, 2016, CareFirst and the Patient-Centered Primary Care Collaborative (PCPCC) convened leaders of safety net health centers and other national experts during a symposium to discuss unique challenges and lessons learned from transforming these safety net health centers into PCMHs. CareFirst also announced plans to award additional funding to the Safety Net Health Centers in 2016.

CareFirst’s CEO, Mr. Chet Burrell, opened the symposium by sharing several key elements of the company’s PCMH program: CareFirst’s model relies heavily on practice transformation – a network of nurse care managers was established to work with primary care provider (PCP) panels to develop care plans for members with multiple chronic conditions. In addition, CareFirst provided an underlying health technology infrastructure and extensive patient data to PCMH providers, so that they can effectively use decision support tools, measure their performance, and engage their patients. Lastly, the shared-saving system, where panels of primary care physicians get a fee schedule increase if they spend less than a budget target based on past spending, was created to ensure financial incentive and provider accountability associated with outcome improvement.

During a following panel discussion with the Safe Net Health Center Program grantees, leaders from these health centers reiterated the importance of patient-centered, coordinated, and team-based care in helping them better work with underserved populations. With resources and technical assistance support from CareFirst, safety net health centers were able to develop a team-based culture, create and implement care plans, and build programs such as emergency room diversion to keep patients in care. However, challenges remained – several safety net health centers noted that practice transformation takes time; some PCPs were still adapting to the shift toward a patient-centered culture. Panelists also described the difficulties in measuring outcomes in safety net environments, where 30 to 40 percent of the transient

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3 CareFirst is working closely with its safety net partners to evaluate the ongoing effort to repeal the Affordable Care Act’s coverage provisions, and the impact on community health centers and the people they serve, to determine the appropriate size and scope of future grantmaking. For more information and receive updates, please visit [www.carefirst.com/community](http://www.carefirst.com/community).
patient population are uninsured. Though most safety net health centers had begun investing more heavily in IT infrastructure for measurement and care coordination, they believed that hospital partnerships were needed to sustain progress, as safety net health centers lacked the capital and access to claims data.

Marci Nielsen, the President & CEO of PCPCC, echoed safety net health centers’ concern for the lack of performance targets across public and private payers, as it impedes the ability to design, implement and measure the effectiveness of value-based purchasing models, such as the PCMH. Among many factors that influence the movement toward paying for quality, Ms. Nielsen emphasized that leadership, culture, and partnerships between payers, providers, and patients are the driving force behind care delivery reform.

Symposium participants agreed with Ms. Nielsen during a roundtable discussion. The foundation of the PCMH culture, they noted, lies within empowered patients who are engaged and supported. Although other methods should still be explored, safety net health centers were making strides in improving patient-centered interactions by inviting patients to serve on advisory boards, engaging them in quality improvement efforts, or gathering feedback via surveys. Furthermore, commitment, compassion, and respect from leadership and individuals on the care team are critical in establishing and maintaining the patient-centered culture and approach.

**Keynote: The Importance of Care Coordination to the Medically Underserved**

Melinda Abrams, the Vice President of Delivery System Reform at the Commonwealth Fund, shared her organization’s work with the PCMH model, state Medicaid programs, and their five-year Safety Net Medical Home Initiative. With a goal to develop a replicable and sustainable implementation model to transform safety net primary care practices into PCMHs, the demonstration program shed meaningful light on practice transformation. The “Change Concepts for Practice Transformation” framework was developed to describe eight change concepts (divided into four stages) that are critical to payment reform:

I. Laying the Foundation: Engaged Leadership and Quality Improvement Strategy
II. Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships
III. Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions
IV. Reducing Barriers to Care: Enhanced Access and Care Coordination

Ms. Abrams acknowledged that payment reform alone cannot lead to successful practice transformation - it can only be achieved when coupled with strong technical assistance support. She shared a collection of technical assistance tools that focus on the following three areas:

I. Practice facilitation
II. Learning communities
III. Data monitoring
Shifting to the other side of the healthcare industry—the PCMH model has significant impact on the provider community. Panelists shared that serious barriers persisted for safety net health centers to provide high-quality, coordinated care. Safety net health centers continue to fight for funding, as federal grants account for only 20 percent of safety net revenue. Despite the growing demand for safety net health center services from underserved populations, they were excluded from Center for Medicare and Medicaid Services (CMS) value-based programs. In addition, safety net health center providers were constantly challenged by lack of continuity of care, access to data, and opportunities for relationship building, which is unique to the population they serve. Though far from perfect, the PCMH model offered providers a better option to improve care quality and clinical outcomes. Panelists also discussed that a carefully chosen small number of measurements may better improve quality and track progress during PCMH implementation. When thinking about the future of value-based purchasing, panelists agreed that there may be more value in designing programs that also meet individuals’ social needs in primary care settings.

**Conclusion:**
As the PCMH model matures from its early stage, the data revealed its capability to lead to real system transformation. It may require greater time to realize significant results, captured by deliberately designed outcome measures. Lessons from CareFirst’s Safety Net Health Center Program are significant contributions to the PCMH movement as safety net health centers continue to build true “medical homes” that serve the most vulnerable populations in the country. Future funding, resources, and IT infrastructure are needed for safety net health centers to complete their transformation into high-performing PCMHs.
Mr. Burrell shared three personal and family experiences highlighting his respect and admiration for community health care centers, his gratitude for their role caring for the underserved, and his wish that no one take them for granted. Indeed, these experiences stimulated CareFirst’s earliest research and testing of two ideas – that everyone should have a “home” for their health care needs and that financial incentives and provider accountability could improve outcomes. A pilot CareFirst PCMH model revealed that a common method of creating “medical homes” that focused on practice transformation and offered set per member per month fees for participating physicians, achieved little in improving quality and controlling costs. Accordingly, CareFirst developed its signature PCMH Program which – among components that include access to rich patient data and incentives for participation and health and cost outcomes – relies heavily on the use of nurse care managers to work with primary care providers to develop care plans for members with multiple chronic conditions. Ultimately, CareFirst built a network of nurse care managers hired from communities served by CareFirst’s primary care panels, and the nurses began working with members to help them adhere to the their care plan.

I have been struck by one other thing visiting community health care centers. Not enough people talk about that, no matter where you go, you are struck by the extreme dedication to the people they serve. The amount of time, attention, and devotion provided, without compensation, is a hidden subsidy that allows people to get more than just health care.
- Chet Burrell

The current CareFirst PCMH program launched in January 2011, during the earliest stages of Affordable Care Act implementation. Mr. Burrell noted that while the ACA promised access to affordable quality health coverage, most of the coverage gains in CareFirst’s service area were via Medicaid expansion, and 29 million Americans still lack coverage. Though many people expected the ACA to eliminate the need for community health centers, Mr. Burrell described them as never being more important, as they not only continue their important role providing medical care to help those who lack coverage, they connect them with behavioral health, housing resources, transportation and other social services and supports.

The CareFirst PCMH program now includes more than a million CareFirst members, 90% of the primary care providers in Maryland, DC and Northern Virginia, and manages $5 billion a year in medical expenses on behalf of the members it serves. CareFirst estimates medical costs for PCMH members have been $794 million less than expected, and peer-reviewed publications
estimate the program has lowered medical trend by nearly 3%. The program has also improved the quality of care provided, leading to fewer hospital admissions and readmissions and shorter lengths of stay.

CareFirst believed that if community health centers could similarly improve quality to lower costs, they could better use their resources to care for the underserved. This is particularly important because federal grant funding only accounts for 20% of community health center funding, and that the population they serve may benefit even more from the patient-centered approach to advanced primary care found in CareFirst’s commercial PCMH program. As such, CareFirst funded $7.1 million to support a Safety Net Patient-Centered Medical Home Initiative. Mr. Burrell welcomed leaders of the participating community health centers, thanked them for their work, and appreciated the opportunity for CareFirst to hear about their successes, challenges, and lessons learned. He closed by recognizing that federal funding and payer reimbursement is not enough to pay for care coordination, and that many community health centers lack the health information technology infrastructure and data and analytics capabilities necessary to provide advanced primary care.

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Mr. Burrell asked each panelist to explain the most productive outcome and the major lesson learned from implementation of a PCMH program in a safety net health center. Maria Gomez described Mary’s Center’s evolution from episodic patient treatment to an interdisciplinary patient-centered approach, to holistic care. Though Mary’s Center focused on hypertension, diabetes, and asthma, they lacked the specific staff to help primary care providers and patients develop or benefit from care plans. The CareFirst Safety Net PCMH initiative helped them overcome this barrier. For example, all staff – starting with the front desk – have become more patient-centered, which has helped patients appreciate the value of having a team focus on their health beyond the care provided at the clinic.

Vincent Keane discussed the unique challenges faced by community health centers due to patients being homeless, recently being released from jail, or having other hardships that made keeping them in care difficult. CareFirst funding helped Unity Health Care develop after-hours care and emergency room diversion activities and outreach to out of service patients. The alignment of public and private payment mechanisms, and the financial support provided by CareFirst, is essential to keeping people in care. Mr. Keane also described the challenge of medical education which has historically focused on physicians practicing as individuals, and how changes in payment, culture, and PCMH techniques (e.g., care plans, huddles) are leading to team based care.

Kathleen Knolhoff described how the CareFirst grant funding and technical assistance helped CCI Health and Wellness Services learn how others provided team based care, and hire nurse care coordinators and community health workers to build patient-centered teams and implement care plans. The gradual shift to patient-centeredness since 2012 has transformed the way they provide care. They remain challenged by a lack of time for strategic planning and practice transformation, and primary care providers who may still not be used to working through others to achieve better outcomes. They are continuing to work on helping patients manage their health outside the clinic, and overcoming challenges arising from social determinants of health.

Faye Royale-Larkins agreed that Total Health Care’s greatest success arose from the challenges described by the previous panelists. Their medical providers and administrators have transformed from a model of “medical benevolence,” in which they were guided by compassion but believed they knew what was best for patients, to a model where the patient is at the center of the care team. This required health care professionals, administrators, and staff to
assess where they fit and how they could best support the team. They continue to focus on patient activation, and helping their population become more empowered to care for themselves and work with their team.

Mr. Burrell then asked the panelists to reflect on their work, and describe how they measured results.

The discussion shifted to the difficulties in measuring results in a safety net environment. Maria Gomez described the difficulty of longitudinally measuring success in a transient population where 40% of their annual population is new each year and 30% will leave the practice, compounded by an inability to get claims data from Medicaid Managed Care Organizations (MMCOs) and see patients’ complete interaction with the health care system. However, better communication between members of the team and the patients they care for, has led to higher patient satisfaction and an ability to better understand how Mary’s Center is serving them.

Vincent Keane described how his organization combined mission with measurement, and used the Uniform Data Set developed by the Health Resource and Service Administration’s Bureau of Primary Care to focus on clinical outcome (e.g., HbA1C) and process measures (e.g., immunization rates) and improve their outcomes in multiple measures. He also explained how increasing competition from hospitals for insured patients means that there is an imperative to focus on metrics and data rather than the historical focus on benevolence.

Kathleen Knolhoff described CCI’s challenge with measurement, but indicated that an increased focus on measurement allowed them to see progress in patients with targeted chronic conditions. She noted that while measurement isn’t as helpful in recognizing improved access as it is in tracking clinical outcomes, it has helped them prioritize finite care management resources when caring for a population that is still 30% uninsured.

Faye Royale-Larkins described the challenge of using measurement to determine which intervention (e.g., hospital discharge planning, community health worker home visits, care coordination, team huddles) is most effective in reducing admissions or readmissions. She also described how payment innovation has led them to understand how helping patients is best done by reducing acute care, not increasing a hospital census.

Panelists also described how community health centers have begun to invest more heavily in IT infrastructure to meet these ends, but also believe that hospitals must come to the table with health centers and recognize their importance. The Maryland Medicare waiver has led hospitals to invest more in primary care and partner with community health centers, but the payment benefits of the new waiver in Maryland primarily accrue to hospitals rather than safety net health clinics. They also described sustainability and payment innovation as challenges, since patient attribution is difficult in the safety net population their organizations lack the capital to invest in health information technology, can’t get the claims data needed to use Health Information Technology to its potential, and because Medicaid doesn’t pay for ancillary services. However, state primary care associations have assisted in establishing clinical data
warehouses that will be helpful in identifying opportunities for care coordination and measuring success, though it will never be as comprehensive or timely as it is in the commercial population. Mr. Burrell described how even dated claims data can help primary care providers see patterns suggesting a need for quality improvement, even if the data can’t be used for real-time interventions.

Maria Tildon, CareFirst’s Senior Vice President of Public Policy and Community Affairs, concluded the panel by thanking the panelists, recognizing and similarly thanking the other participating health centers, and reiterating that the ACA’s coverage gains have not eliminated the need for philanthropic organizations to support community health centers.

*Community health centers have been around for 50 years. We felt we were doing God’s work and that satisfied us. Now we see that if you don’t improve quality and reduce costs we will be left behind. We had a 35% reduction in no shows, as a result of going to people’s homes and integrating them. That’s an example of care coordination, because no shows are a problem for us and many health centers. – Vince Keane*

*Physicians, nurses, and support staff all come with their own training, and a desire to provide the best service they can. Patient-centered care requires a different focus and different accountabilities. Culture change doesn’t happen overnight. We can take the variation out of care. We can put the right team together for the patient. And we’ll know we’ve made that cultural shift when it becomes so hardwired that it’s who we are and we don’t have to think about it. - Faye Royale-Larkins*

*This has been a wonderful experience, your funding has allowed us to start implementing and expanding exponentially. With the large interdisciplinary care team, we needed something to tie everything together to coordinate the patient’s care. The care plan helps us to see all the services being provided to each patient, in one place. The team can see how the patient has been served, when, by who and what are the individualized goals and outcomes. We are grateful to CareFirst for enabling us to see the total patient. – Maria Gomez*

*CareFirst said, “We know how we do it. We need to know how you all can do it.” There was not a cookie cutter approach, because we were all coming from different places. This grant allowed us to hire nurse care coordinators and community health workers who are able to receive information we wouldn’t have any other way. The PCMH concept was very new to us. Now we have an integrated team approach that has been developed since 2012, and has transformed the way we provide care. – Kathleen Knolhoff*
The nurses work with the primary care provider and the patient, get what is needed documented in the care plan, and take a load off the PCP by working with the patient to make sure it gets done or report back when it doesn’t. We’ve found, as many of you have said, that patients relate well to their nurses and tell them things they may not necessarily tell their doctor. – Chet Burrell
Welcome & State of PCMH Movement

Marci Nielsen, Ph.D., MPH, President & CEO, Patient-Centered Primary Care Collaborative

Marci Nielsen described how the health care system has historically only paid for treatment when people are sick, and the goal is to improve people’s health before illness occurs. Though there has been considerable momentum in shifting towards paying for value from paying for volume, the patient-centered medical home movement is still in its early stages. Research data has shown that the model of care can work, but reducing cost and decreasing utilization are only short-term measures. More investment is needed to measure the effectiveness of the PCMH model to improve health outcomes.

However, lack of common performance targets across public and private payers complicates the ability to design, implement, and measure the effectiveness of paying for quality -- which slows the pace of practice transformation and leads to provider burnout. Simplifying the measure sets providers are required to report, harmonizing measures across payers, and aligning payment incentives are important steps towards broader adoption of value-based purchasing. Much of the PCPCC’s important work is focused on studying PCMH panel variables including practice size, panel culture, and patient population, as well as the myriad approaches to payment innovation (e.g., infrastructure funding, payment incentives, shared savings bonuses) and technical assistance to determine their effect on improving outcomes and reducing costs.

Payers like CareFirst are leading the way with their experience towards value-based purchasing, which requires more than just hiring care coordinators and offering provider incentives. The importance of building a health information technology infrastructure, increasing the capacity for primary care with PCMH panels and interdisciplinary teams, and defining and measuring the ideals outcomes and linking them to payment cannot be overlooked.

However, as many grantees have learned, leadership and culture are perhaps most important to the success of advanced primary care, because health is more personal than it is technical. For many, financial incentives are not the most important driver of change. More partnerships between payers, practices and patients are needed to determine the most effective combinations of goals, incentives, tools, and technical assistance necessary to achieve, maintain, and spread practice transformation.

What are the incentives that keep your team willing to participate in this hard work? It is not always money. Sometimes money can’t buy you love, sometimes it’s love.

- Marci Nielsen
Keynote: The Importance of Care Coordination to the Medically Underserved  
*Melinda Abrams, M.S., Vice President, Delivery System Reform, The Commonwealth Fund*

Melinda Abrams described the Commonwealth Fund’s work in strengthening primary care via the PCMH model, their ongoing work with state Medicaid programs, and key insights from the Safety Net Medical Home Initiative, a five-year demonstration supporting 65 safety net primary care sites as they implemented patient-centered medical homes, with a goal of developing a replicable and sustainable implementation model to transform safety net primary care practices into patient-centered medical homes.

**What’s needed for safety net practice transformation?**

Melinda acknowledged the epic whole-practice re-imagination and redesign described in the literature documenting the earliest attempts at PCMH and practice transformation⁵, and offered great respect and empathy for the PCMH providers in the audience. Practice transformation involves change concepts, a technical assistance package supporting change, and payment reform. The eight change concepts contained in one framework for practice transformation begin with **laying the foundation** through **engaged leadership** and a commitment to a **quality improvement** strategy, **building relationships** through PCP empanelment and continuous, team-based healing relationships, **changing care delivery** through organized, evidence-based care and patient-centered interactions, **reducing barriers to care** through **enhanced access** and, ultimately, **care coordination**.⁶ Nine years of evidence suggest that the foundation alone doesn’t yield cost savings, but practices attempting to start with care coordination without building the foundation run the risk of not achieving sustained practice transformation.

**Laying the Foundation**

The most successful practices have “adaptive reserve,” or the ability to learn and change. Leaders of effective practices envision a future, facilitate staff involvement, dedicate time and resources to changes, and review and act on the data. They build a culture in which current and new employees are part of PCMH implementation, and given time and resources to improve quality. Practices that don’t routinely measure and review performance data, or treat PCMH as a siloed project, are unlikely to improve.

**Building Relationships**

Practices that build relationships by assigning patients to providers and teams change the culture of practices and the accountability of providers. Though safety net patient and provider turnover makes empanelment challenging, it is achievable and essential to patient-centered interactions, and to providing organized, evidence-based care and care coordination. As many

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of the CareFirst grantees stated, team-based care of the chronically ill is the single most powerful intervention, and more effective use of community health workers and medical assistants can help.

**Changing Care Delivery**
Successful sites change care delivery by assessing patient and family needs and preferences, systematically involving patients in decision making (i.e., nothing about me, without me), and involving patients and families in quality improvement via patient and family advisory councils or other mechanisms. They also train *all* staff on patient communication and engagement techniques (e.g., teach-back), not just clinicians.

**Reducing Barriers to Care**
The evidence of cost savings comes primarily from improvements in care coordination and access. Expanding office hours by just a few hours per work is associated with reduced emergency department use. Successful practices don’t leave care coordination to chance, they embed it in their daily work.

**What are key features of technical assistance to support safety net sites and their transition to PCMH?**

**Practice Facilitation**
It is hard to coach yourself. Hiring an external coach dedicated to the practice or site can help practices see and stay on the path to change, assess needs and priorities, train teams on change management and practice management skills, and identify tools to support the work. Working with a coach in this regard does not require yielding control. One coach can effectively work monthly or quarterly with 5-7 practice sites, and a network of coaches can help share and spread ideas. Assessments used by government PCMH initiatives today were originally designed by the safety net community.

**Learning Communities**
The evidence suggests sites learn best from one another, and peer networks help spark and maintain momentum. Some practice transformation concepts are difficult to teach, but easy to see, and field trips have been ranked as the most valued form of technical assistance. A learning community network is also useful in providing ongoing support to practices, and can facilitate spread and sustainability.

**Data Monitoring**
The evidence affirms what the panelists suggested earlier. Data monitoring is important, but it is difficult when capacity or resources are limited. It is important for practices to select and focus on the measures most meaningful to them, from the domains of clinical quality, utilization, transformation, patient experience, and provider and staff satisfaction. What you measure depends on what you want to use it for (i.e., patient care measures are different than payment incentive measures). The PCMH-A tool is in the public domain, and often used every six months. Melinda shared a quote from the literature about the ability of measurement to
show improvement and inspire practice transformation, and practical tips to data monitoring and quality improvement.

**Conclusion**

Melinda concluded by reiterating an important point made by Marci Nielsen. Payment reform can achieve practice transformation when it is combined with technical assistance, but payment reform alone cannot cause practice transformation. She described a number of helpful tools and implementation guides that are available at http://www.safetynetmedicalhome.org on the web.

Trust is important to transforming the culture of a practice. The relationships within a site, across the sites within an organization, and with the providers and organizations to whom community health centers refer, is far more important to transformation than a mechanized approach to quality improvement.

- Melinda Abrams

**Panel: What Does Value Based Purchasing Mean for Safety Net Providers?**

*Moderator: John O’Brien, PharmD, MPH, VP Public Policy, CareFirst BlueCross BlueShield*

*Panelists:*

- Jonathan Blum, MPP, Executive Vice President, Medical Affairs, CareFirst BlueCross BlueShield
- Stephanie Glover, MPAff, Health Policy Analyst, the National Partnership for Women and Families
- Nilesh Kalyanaraman, MD, Chief Medical Officer, Health Care for the Homeless
- Len Nichols, Ph.D., Director of the Center for Health Policy Research and Ethics and Professor of Health Policy, George Mason University
- Sara Rosenbaum, J. D., Professor, George Washington University

John O’Brien began the panel by noting that Federal grants account for only 20% of safety net revenue, and 65% of community health center budgets depend on public and private payer payments. It had been assumed that the ACA would reduce the strain on safety nets due to reduction in uninsured and greater reimbursements from private payers, but the evidence has suggested a shifting, not shrinking, demand for community health center services. Furthermore, Medicare and Medicaid pay community health centers via a prospective payment system that does not explicitly pay for care coordination, and the CMS Quality Payments Program, created by the Medicare Access and CHIP Reauthorization Act and a major driver in the move to value-based payments, does not currently allow community health center participation. What does this mean for community health centers seeking to provide PCMH services?

Len Nichols reflected on the challenges previous panelists had getting data from Medicaid MCOs and hospitals in their service area. He contrasted that to Fairfax County, Virginia, which self-funds Molina Healthcare to run 3 community health centers, which are a source of care for
100,000 county residents not eligible for Medicaid. These centers have strong IT systems capabilities which enabled intensive data analysis about gaps in care, particularly when serving the non-Hispanic minority community in Fairfax. By providing financial bonuses to providers and administrative staff for closing these gaps in care, the health centers were able to improve clinical outcomes and quality of care. He provided this example to show that safety net health centers have similar challenges to other primary care practices, and that good leadership, good data, and good systems can improve quality, particularly when used to convince a payer to engage in payment reform.

Sara Rosenbaum provided a 30-year history of Federal prospective payment systems, which she originally developed with Senator Chafee for Federally Qualified Health Centers (FQHC). In the late 1980s, 1 in 4 patients in health centers were enrolled in Medicaid, but the Medicaid agencies were only paying 15% of their costs. Grant financing, which came from another Senate committee, was cross-subsidizing Medicaid in community health centers, and reduced the number of uninsured patients they could see. The FQHC payment system was designed to stop that practice, so the grants could be based on and used for uninsured patients. Today, community health centers are free to negotiate Medicaid payment with states and move from encounter-based payments to a value-based payment system. Indeed, 6 or 7 states have done so, and have incentives to substitute office-based care with telehealth or other approaches, replace high-cost care with low-cost care, and make better use of data. Change is happening slowly because payers and providers have not yet negotiated these new methods of payment. It will be difficult to achieve the type of practice transformation discussed today and deeply discount the cost of medical services.

Nilesh Kalyanaraman described the important role of community health centers for people experiencing a break in coverage and a break point in their lives. They are more than just a health care provider to most patients, and serve as a stopgap to connect patients with housing, social services, and many other functions. Nearly 40 percent of patients are only seen one time, and it is hard to provide the continuity of care, care coordination, and relationship building that are important to PCMH success. Indeed, many don’t want to have a long-term relationship with a safety net health center. Regardless of the patient population, a lack of data and conflicting sets of payment rules make it difficult to provide care and manage attribution or other payment model requirements.

Jon Blum explained how many policymakers incorrectly assumed that the Affordable Care Act would cover the uninsured and the need for safety net funding would diminish. They may also wrongly assume that bundled payments and capitated payments would solve everything. Community health centers are challenged by patients seeing multiple providers, and lack the data to see the big picture, and data from fee-for-service encounters remains necessary to track progress, ensure accountability, and understand patients’ complete health care experience. The community health center community can help challenge these assumptions.

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7 Virginia did not implement the Medicaid expansion permitted by the Affordable Care Act.
Stephanie Glover shared the National Partnership for Women and Families’ (NPWF) belief that improving patient care should always be the goal of practice transformation. Holding providers accountable for clinical outcomes and patient experience requires having patients involved in transformation. Patient experience surveys are a good starting point, but more complete patient engagement comes from involving them on advisory boards, committee structures, and other models of active involvement. NPWF is actively involved in helping health care providers become more patient centered, and they are available to partner with others.

The moderated discussion began with a question on measurement and evaluation. Len and Jon described the value of mixed or conflicting results as an opportunity to learn. Policymakers have a desire to quickly know what is or isn’t working, but it is rarely a binary question. A long-term, more global focus on why models achieve different results is necessary because different models work well in different places for different reasons. Patience and confidence with the approach is also important to prevent early termination of models that have the potential to achieve progress.

Dr. Kalyanaraman described his challenge as an administrator who still practices when caring for a high volume of patients and collecting and reporting quality measures. He reiterated Melinda Abrams’ suggestion of choosing and focusing on a small number of measures that are most important to the practice. Focusing on a limited set of measures may feel limiting, but in practice it improves quality more than being overwhelmed by trying to do focus simultaneously on many different measures. Such an approach can also lead to greater provider buy-in. Jon shared his experience that qualitative or subjective HEDIS measures may not move the needle as much as measures of physician engagement or patient engagement.

Ms. Glover also described how patient experience measures and patient-reported outcomes can also create feedback loops within a practice that can improve other measures, and Sara agreed that asking the right questions can help prioritize measurement and help practices focus. For example, knowing whether or not a patient planned on starting a family can eliminate unnecessary reproductive health measures, and knowing the reading level of patients and families has served as an effective risk adjuster. The answers to these questions can also be used to determine workload and payment.

A question about medical education yielded insight from the panelists about health professionals in training being more aware of the importance of social determinants of health, and the link between health equity and population health outcomes.

The panelists described how telemedicine and e-health consults can benefit patients and health care institutions alike, but noted that someone has to be willing to pay for it. The use case of telemedicine is an important payer consideration when choosing to cover telemedicine services. Too often the focus is on the payment rule, and not the kinds of services in which it can be most useful. There may be more value in using telemedicine for subsequent visits than initial visits, but payment rules often don’t allow such flexibility.
Community health center patients frequently have non-medical issues complicating their health. Value-based purchasing may too often focus on clinical outcomes, when there may be more value in discussing and meeting social needs. Asking patients about their experience and quality of life can yield better data about whether community health centers are improving health, perhaps beyond the clinical outcomes themselves. Co-locating medical and social services professionals can also address all the patient’s needs during a primary care visit.
Following the panel discussion symposium participants selected one of two roundtable discussions led by Tiffany Tate, CareFirst Safety Net Health Initiative Project Manager, and Marci Nielsen.

Roundtable- Leadership & Culture/Team Based Care  
Moderator: Tiffany Tate, MHS, CareFirst BlueCross BlueShield

Tiffany Tate facilitated the roundtable, which was an open discussion between safety net leaders, staff, and academics. She introduced the theme of the session and explained that the group was charged with exploring the impact of key elements and issues related to leadership and culture in safety net settings.

The discussion began with a free-association exercise aimed at devising a common definition for PCMH culture. Participants offered that the foundation of a PCMH culture should be an empowered patient who is supported by engaged immediate and extended family. A care team that extends parity to every team member was cited as an essential component of a patient-centered culture. It was agreed that assigning and internalizing equal value to the contribution of patient, family members, and health care providers and staff solidifies the culture.

Participants mentioned compassion, respect, and appreciation for individual care team members’ differences as both an opportunity and challenge in creating a patient-centered environment. There was consensus that open-mindedness and a commitment to understanding the desires and intentions of each person on the team are critical to thoughtful, innovative, customized care plans that increase the likelihood of positive outcomes.

Having a leader to establish and maintain a culture of patient-centeredness was deemed the most essential element in achieving success. It was noted that the leader of the transition to a PCMH culture could hold any position in a practice. Desirable traits of the “PCMH Champion” included enthusiasm, compassion, consistency, longevity, and the ability to motivate others. The group agreed that the champion must demonstrate and inspire an environment where patients feel safe and staff feel supported in the transition and confident in the longevity of the patient-centered approach.

Finally, participants acknowledged that performance and health care outcomes are central to the viability of patient-centered models and, thus, must be incorporated into the culture. Increasingly, the ability to evaluate qualitative and quantitative impact is required of PCMH providers to substantiate eligibility for performance-based funding or reimbursement. Participants noted that accuracy in reporting outcomes is dependent on data collection and tracking systems and evaluation methodologies that account for the true acuity level of their patient population. The majority of the group stated that safety nets often lack the financial and human resources to implement a comprehensive data collection and reporting system that meet the aforementioned criteria.
Marci Nielsen kicked off the roundtable by pointing to the fact that FQHCs are required to have 51% of their board members be patients. Given that nearly all of the roundtable participants represented FQHCs, they had already taken an important step towards patient centeredness. She suggested that there are 3 key ways through which to engage patients:

- Have patients serve on the board
- Engage patients in Quality Improvement efforts
- Utilize patient surveys

When the roundtable was surveyed, nearly all participants indicated that their health center had patients serve on the board and utilized surveys, but only one representative indicated that they have engaged their patients in Quality Improvement efforts. Participants’ experience had been that having patients serve on the board was difficult because of the transient nature of the population and often unrealistic requests. Health center representatives also discussed how their organizations had defaulted to and were overly reliant on patient surveys. The surveys were often overly complex, particularly for those with low levels of literacy. Even the answers were difficult for patients to understand, with answers of “definitely yes”, “yes”, “maybe”, etc. Ms. Nielsen agreed that it is tough for the general public to understand this complexity due to their experience with simpler product surveys. There are 64 questions in the CAHPS survey, though there are efforts underway to reduce this to just 10 categories. Marci concluded the roundtable by sharing a variety of resources that safety net health centers could use to assist with patient engagement.
Conclusion
The symposium covered a broad range of topics specific to the PCMH model, payment and delivery transformation, and safety net health centers. While PCMH is still in the relatively early stages of development, the data has revealed its capability to allow for value-based purchasing with outcomes focused on quality rather than quantity. However, it is not a universal model that can be implemented in the same manner in all settings. Safety net health centers have a particularly unique set of challenges due to serving as more than just a health care provider, but as a key stopgap for those with a wide variety of needs in often-challenging life circumstances. The transience of the safety net population and inability to obtain Medicaid data make obtaining a longitudinal picture of the patient very difficult. The CareFirst PCMH Safety Net Health Initiative allowed health centers to work through these challenges, and participants were hopeful that the future funding will spur continued progress towards transforming delivery of care for the underserved.
Epilogue

Since the event, an election resulting in a Republican president and maintenance of a Republican majority in the House and Senate has created uncertainty for community health centers. The looming primary care funding cliff, the potential repeal of the Affordable Care Act and its impact on Medicaid expansion, and discussions of Medicaid block grants are among the many looming concerns for safety net health providers and others in health care.

Taken together, these recent developments represent both a threat and an opportunity to community health centers. We will be working with our safety net partners as these developments unfold, and seek their advice about whether our investment should remain focused on PCMH programs or other community health center priorities.

As we serve our community partners and enter a time of uncertainty we are committed to continue our mission and to support our community partners.
Speaker Bios

Melinda Abrams, M.S.
Vice President, Delivery System Reform, The Commonwealth Foundation
Melinda K. Abrams, M.S., is Vice President of the Commonwealth Fund's Health Care Delivery System Reform Program. Since joining the Commonwealth Fund in 1997, Ms. Abrams has worked on the Task Force on Academic Health Centers, Commission on Women's Health, and most recently, the Child Development and Preventive Care programs. She played a lead role in conceptualizing and launching the Fund's Assuring Better Child Health and Development (ABCD) initiative, which awarded grants to state Medicaid programs to encourage innovation in the financing and delivery of preventive and developmental services provided to low-income, young children.

Ms. Abrams sits on a number of national committees, including the Board of Managers of TransforMED, the PCMH Advisory Committee for the National Committee for Quality Assurance, and two Medical Home Expert Panels for the Agency for Healthcare Research and Quality (AHRQ). In addition, she is a peer-reviewer for the Annals of Family Medicine. Ms. Abrams holds a B.A. in history from Cornell University and an M.S. in health policy and management from the Harvard School of Public Health.

Jonathan Blum, MPP
Executive Vice President, Medical Affairs, CareFirst BlueCross BlueShield
Jonathan (Jon) Blum is the Executive Vice President for Medical Affairs at CareFirst BlueCross BlueShield, which provides health care coverage in Maryland, the District of Columbia and Northern Virginia. Jon has responsibility for overseeing CareFirst’s nationally recognized Patient-Centered Medical Home program. He also oversees CareFirst’s medical and care coordination policies, pharmacy policies, and provider networks.

Prior to joining CareFirst, Jon served as the Principal Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS), leading CMS’s payment and delivery reform strategies and overseeing the Medicare program’s policy and management. He also served on the professional staff of the Senate Finance Committee and as a Medicare program analyst at the White House Office of Management and Budget. He earned a Master’s degree in Public Policy from the Kennedy School of Government at Harvard University and a Bachelor’s degree from the University of Pennsylvania.

Chet Burrell
President & CEO, CareFirst BlueCross BlueShield
Chet Burrell joined CareFirst BlueCross BlueShield in December 2007. He has more than 40 years’ experience in the health care industry, including serving as President and Chief Executive Officer of RealMed Corporation, a provider of online claims processing services; and as
Chairman and CEO for Novalis Corporation, a managed care technology and consulting company.

He has also served in senior-level positions for Anthem and Empire BlueCross BlueShield plans and Blue Cross of Northeastern New York. In addition to his private sector health care experience, Burrell has also served in the New York State government in a variety of capacities, including the Offices of Mental Health and Health Systems Management and as a member of the New York Governor’s Staff.

Mr. Burrell earned his Bachelor’s degree in Sociology and Political Science from Allegheny College and a Master’s degree in Public Administration from the University of Albany. He serves on the Boards of the DC Chamber of Commerce, the Greater Baltimore Committee’s Executive and Health Care Committees, the Greater Washington Board of Trade and the Council for Affordable Quality Healthcare (CAQH).

**Stephanie Glover, MPAff**  
Health Policy Analyst, The National Partnership for Women and Families  
Stephanie Glover is a Health Policy Analyst for the National Partnership for Women & Families. Stephanie manages the National Partnership’s federal health policy portfolio related to health care transformation and comprehensive payment reform. In this role, she advocates for new models of care and payment that provide the comprehensive, coordinated care that patients want and need. Stephanie also directs the National Partnership’s Coalition for Better Care, a coalition of consumer organizations with a direct stake in improving health care quality for patients and family caregivers.

Stephanie has a Masters of Public Affairs from the Lyndon B. Johnson School of Public Affairs at the University of Texas and earned her undergraduate degree at Trinity College in Hartford, CT. Stephanie has previously worked at the National Women’s Law Center, the Child and Family Research Partnership, and the Women’s Campaign Fund.

**Maria Gomez, RN, MPH**  
President and CEO, Mary’s Center  
Maria S. Gomez is the founder of Mary’s Center, a community health organization providing health care, education and social services. Under Maria’s leadership, Mary’s Center has grown from an initial budget of $250,000 serving 200 participants at a basement in 1988 to an annual budget of $42 million serving over 36,000 individuals in the District of Columbia and Maryland. Maria has received numerous local and national important recognitions, including the 2012 Presidential Citizens Medal, the nation’s second-highest civilian honor. In 2015, Maria also received the Hispanic Heritage Foundation Healthcare Award, the Montgomery Country Hispanic
Heritage Public Service Award and the Washington Business Journal Women Who Mean Business Award. Originally from Colombia, South America, Maria holds a Bachelor of Science degree in Nursing from Georgetown University and a Master’s degree in Public Health from the University of California at Berkeley. Prior to establishing Mary’s Center, Maria was a public health nurse with the D.C. Department of Health. She also worked for the Red Cross and the Visiting Nurses Association.

Nilesh Kalyanaraman, MD
Chief Medical Officer, Health Care for the Homeless
Dr. Nilesh Kalyanaraman is the Chief Medical Officer of Maryland’s Health Care for the Homeless, Inc. (HCH). He directs Adult Medicine, Pediatric & Adolescent Services, Dental Services, and Psychiatry. Previously he spent four years at Unity Health Care in Washington, D.C., where he was the Assistant Medical Director for health services at the D.C. Jail. Subsequently, he was an AAAS Science and Technology Policy Fellow at the National Institute of Health from 2010-2011, where he worked at the National Center for Complementary and Alternative Medicine. Nilesh completed his residency in Internal Medicine at Emory University, received an MD from SUNY Brooklyn School of Medicine, and a BS in Chemistry from Yale University.

Vincent Keane
President and CEO, Unity Health Care, Inc.
Vincent A. Keane is currently President/CEO of Unity Health Care, Inc. (Unity), Washington, D.C. Unity, a Federally Qualified Health Center (FQHC) and a non-profit organization, provides primary health care, psycho-social services and mental health care to the medically underserved in Washington, D.C. Beginning in 2006, Unity began providing health care services to the inmates in the D.C. Department of Corrections (DOC) and continues to do so to date. Last year, Unity served 93,000 individual patients, and generated over 613,000 patient visits.

As well as his executive responsibilities for Unity, Mr. Keane is actively involved in the development of national health care policy as it addresses the needs of the medically underserved and poverty communities. He is regularly called upon to testify before the City Council of the District of Columbia.

Since 1969, when Mr. Keane came to the United States, he has been involved in the non-profit sector including work in the Catholic Diocese of Arlington providing social services and pastoral care within several parish communities. From 1987 to 1990, he served as Director of Development for the National Association of Community Health Centers (NACHC). In 1990, he became Executive Director of Health Care for the Homeless Project (HCHP) Washington, D.C., which later became Unity Health Care, Inc.
Kathleen Knolhoff, MPH  
CEO and President, CCI Health & Wellness Services

Kathleen Knolhoff, MPH, is the Chief Executive Officer and President of CCI Health & Wellness Services (CCI). She holds a Bachelor of Science (BS) in Dietetics/Nutrition from the University of West Florida, a Masters of Public Health (MPH) from the University of Alabama at Birmingham, and Graduate Certificate in Survey Design and Data Analysis from The George Washington University, Washington, DC. She has served as the Health Officer for Talbot County, MD and Director of the Maryland WIC Program. Ms. Knolhoff re-joined CCI in 2009 as the Chief Operating Officer, and in 2011 became the Associate Chief Executive Officer. In 2014, Ms. Knolhoff became the CEO and President.

Faye Royale-Larkins  
CEO, Total Health Care

Faye Royale-Larkins is the Chief Executive Officer of Total Health Care, Inc. She leads the organization in the implementation of its strategic goals and manages its day-to-day operations as leader of the executive management team. She directs the development, communication, implementation, and evaluation of long and short-term plans and budgets. She reports to the Board of Directors and regulatory agencies having jurisdiction over the corporation. Mrs. Larkins also effectively oversees the provision of healthcare delivery to patients and the community in accordance with protocols, policies and procedures of the corporation. Mrs. Larkins has more than 30 years of clinical and health executive management experience in community health care, physician group management and hospital operations having served as a senior executive in a variety of settings including community/public health, ambulatory care, and acute care hospitals. Her diverse experiences include working in a senior capacity with government and privately-funded programs, physician practice management, primary and specialty outpatient care in community health centers and hospitals, substance abuse, inpatient and outpatient behavioral health, HIV/AIDS, prevention and wellness, emergency services, community outreach, home health and hospice, community and home dialysis services, clinical research and hospital administration.

Mrs. Larkins grew up in West Baltimore and received her Bachelors of Arts degree in sociology in 1972 from Morgan State University. In 1977, she received her Bachelor of Science of Nursing from State University of New York after earning her Master of Public Health degree in 1974 from the University of Michigan, School of Public Health. She is currently pursuing her doctorate of Health Administration from the University of Michigan.

Her professional affiliations include serving as board secretary for The Sisters Academy School, which provides tuition-free education to girls living mainly in southwest Baltimore; board member and chair of the personnel committee of On Our Own of Howard County, a consumer-run wellness and recovery center, and chair of the Personnel Committee; and board member of Why Murder? , which supports underserved youth in Baltimore at risk of incarceration.
Len Nichols, Ph.D.
Director of the Center for Health Policy Research and Ethics and Professor of Health Policy, George Mason University

Len M. Nichols is the Director of the Center for Health Policy Research and Ethics (CHPRE) and a Professor of Health Policy at George Mason University (GMU). He has been intimately involved in health reform debates, policy development, and communication with the media and policy makers for 20+ years, after he was Senior Advisor for Health Policy at the Office of Management and Budget (OMB) in the Clinton Administration. Since that time, he has testified frequently before Congress and state legislatures, published widely and spoken to a tremendous range of hospital associations, physician groups, and health policy forums around the country.

After OMB, Len was a Principle Research Associate at the Urban Institute, Vice President of the Center for Studying Health System Change, and Director of the Health Policy Program at the New America Foundation. In addition to his positions at GMU, Len is on the Board of Directors of the National Committee for Quality Assurance and an advisor to the Patient-Centered Primary Care Collaborative. Len was an advisor to the Virginia Health Reform Initiative and is now the payment reform advisor to the Virginia Center for Health Innovation as it leads Virginia’s State Innovation Model effort.

As he has come to focus his research more on payment and delivery reform, Len was an Innovation Advisor to the Center for Medicare and Medicaid Innovation at CMS, and is now the Principal Investigator on PCMH evaluation studies as well as more general ways to use payment and delivery reform to achieve triple aim and health equity goals. Len’s first job was teaching economics at Wellesley College from 1980-1991, where he became Associate Professor and Economics Department Chair, after receiving his Ph.D. in Economics from the University of Illinois in 1980. Len got his B.A. from Hendrix College in Conway, Arkansas, and his M.A. in Economics from the University of Arkansas in Fayetteville.

Marci Nielsen, Ph.D.
President & CEO, Patient-Centered Primary Care Collaborative

Marci Nielsen, Ph.D., MPH, is President and Chief Executive Officer of the Patient-Centered Primary Care Collaborative (PCPCC), a non-profit membership coalition of health care providers, patients & families/caregivers, and payers – with a mission to improve the US system by strengthening advanced primary care (via the patient-centered medical home framework).

Marci is a seasoned health policy executive with nearly three decades of state, federal, international, and academic experience, including the development and implementation of innovative policies in public and private health care programs. Marci held previous positions as: Vice Chancellor for Public Affairs and Associate Professor at the University of Kansas Medical Center; Executive Director of the Kansas Health Policy Authority (KHPA) -- the single state agency managing Medicaid, the State Children’s Health Insurance Program, the State Employee Health Plan, health information technology and health policy; the health lobbyist and assistant director of legislation for the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO); and legislative assistant to U.S. Senator Bob Kerrey (D-Nebraska). Early in her career she
served as a Peace Corps volunteer and in the U.S. Army Reserves. She holds a Ph.D. from the Johns Hopkins School of Public Health, an MPH from George Washington University, and a BS in biology and psychology from Briar Cliff College.

Marci serves on the Board of Directors for the American Board of Family Medicine, the National Academy for State Health Policy, and the Collaborative Family Healthcare Association. She is a member of NQF’s Measures Application Partnership (Clinical Workgroup), the Eugene Farley Center for Health Policy at the University of Colorado, and a number of other national and state policy committees. She served as a committee member for the Institute of Medicine’s Leading Health Indicators for Healthy People 2020 and Living Well with Chronic Illness: A Call for Public Health Action.

John O’Brien, PharmD, MPH
Vice President, Public Policy, CareFirst BlueCross BlueShield
John Michael O’Brien is Vice President of Public Policy at CareFirst BlueCross BlueShield, and represents CareFirst on state and federal government and regulatory matters – with a particular focus on quality policy and the role of care coordination in delivery system and payment reform. Dr. O’Brien joined CareFirst from the Centers for Medicare and Medicaid Services (CMS), where he served as Acting Director of the Strategic Partnerships Division, senior advisor in the CMS Innovation Center, and policy coordinator in the Office of Strategic Operations and Regulatory Affairs. Before joining CMS, John was a professor of clinical and administrative sciences at the Notre Dame of Maryland University College of Pharmacy, a Health Policy Fellow in the United States Senate, and held a number of medical affairs and government affairs positions in the pharmaceutical industry. He has a master’s degree in public health from the Johns Hopkins Bloomberg School of Public Health, a doctor of pharmacy degree from Nova Southeastern University, and also studied pharmacy and public policy at the University of Florida.

Sara Rosenbaum, J. D.
Professor, George Washington University
Sara Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University Milken Institute School of Public Health. She also holds a Professorship by Courtesy in the GW Law School and is a member of the faculty of the School of Medicine and Health Sciences.

A graduate of Wesleyan University and Boston University Law School, Professor Rosenbaum has devoted her professional career to issues of health justice for populations who are medically underserved as a result of race, poverty, disability, or cultural exclusion. An honored teacher and scholar, a highly popular speaker, and a widely read writer on many aspects of health law and policy, Professor Rosenbaum has emphasized public engagement as a core element of her professional life, providing public service to six Presidential Administrations and fifteen Congresses since 1977. Professor Rosenbaum is best known for her work on the expansion of
Medicaid, the expansion of community health centers, patients' rights in managed care, civil rights and health care, and national health reform. Between 1993 and 1994, she worked for President Clinton, directing the drafting of the Health Security Act and designing the Vaccines for Children program, which offers near-universal coverage of vaccines for low income and medically underserved children. Professor Rosenbaum also regularly advises state governments on health policy matters and has served as a testifying expert in legal actions involving the rights of children under Medicaid. Professor Rosenbaum is the leading author of Law and the American Health Care System, 2d ed., published by Foundation Press, May, 2012, a landmark textbook that provides an in-depth exploration of the interaction of American law and the U.S. health care system. She has received national awards for her work, serves on governmental advisory committees, private organizational and foundation boards, and is a past Chair of AcademyHealth. She is a member of the CDC Director's Advisory Committee, the CDC Advisory Committee on Immunization Practice (ACIP), and a Commissioner on the Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress on federal Medicaid policy.

**Tiffany Tate, MHS**  
**CareFirst BlueCross BlueShield**

Tiffany Tate is a public health and healthcare consultant who has worked on dozens of local and national initiatives to improve the quality and delivery of health services. Her clients have included local and state health departments, state and federal agencies, hospitals, professional associations, health insurers, coalitions, community-based and non-profit organizations, private providers, and private companies.

Through her diverse experiences, she has acquired subject matter expertise in hospital and health system operations, public health, population health, organizational development, and health insurance.

Currently, Ms. Tate oversees CareFirst’s Safety Net Health Centers Patient-Centered Medical Homes Initiative, an $8.5 million grant project to assist safety nets in implementation of patient-centered care. Tiffany holds a Master of Health Science from the Johns Hopkins University School of Hygiene and Public Health and undergraduate degrees in Health Care Administration and Business.

**Maria Harris Tildon**  
**Senior Vice President, Public Policy and Community Affairs, CareFirst BlueCross BlueShield**

Maria Harris Tildon is Senior Vice President for Public Policy and Community Affairs for CareFirst BlueCross BlueShield, the largest health care insurer in the Mid-Atlantic region, serving nearly 3.2 million members with nearly 5,000 employees in Maryland and the National Capitol Area. As Senior Vice President for Public Policy and Community Affairs, Ms. Tildon is responsible for managing all matters related to public policy, state and federal government relations, external and internal communications, strategic medical communications and community investments and outreach. Tildon joined CareFirst BlueCross BlueShield in September of 2006.
Prior to joining, CareFirst BlueCross BlueShield, Ms. Tildon was Senior Vice President for External Affairs for The Century Council, a not-for-profit organization dedicated to fighting underage drinking and drunk driving. As Senior Vice President, Ms. Tildon was responsible for all communications, marketing, federal and state government affairs and national field efforts on behalf of The Council. Ms. Tildon began her tenure at The Council in November of 1999 after serving in several capacities in the Clinton Administration at the U.S. Department of Commerce under Secretaries Ronald H. Brown and William Daley including Acting Deputy Assistant Secretary for Import Administration and Deputy Director of Public Affairs. As Deputy Director, Ms. Tildon was responsible for oversight of all media relations and outreach efforts for the Department of Commerce’s thirteen agencies and 30,000 employees.

Prior to joining the Administration, Ms. Tildon practiced law at Venable, LLP in Washington, D.C. from 1990-1993 focusing on civil and criminal litigation in federal and state courts with a special emphasis on business litigation and environmental criminal defense.

About CareFirst’s PCMH Program

As the region’s largest private payer, CareFirst undertook the Total Cost and Care Improvement (TCCI) and Patient-Centered Medical Home (PCMH) programs at the start of 2011 as a way to improve health care quality and address the continuing steep increases in care costs occurring in its service area which includes Maryland, the District of Columbia and Northern Virginia.

The TCCI and PCMH Programs that are intended to focus on the root causes of suboptimal quality and continuing cost growth. Beginning in 2011 and continuing through the current period, CareFirst has progressively brought the capabilities now in the TCCI and PCMH programs to full operation.

As of January 2017, nearly 1.1 million CareFirst Members were in the PCMH Program while all 3.2 million CareFirst Members are served by one or more elements in the TCCI Program. Fueled by an Innovation Award from the Centers for Medicare and Medicaid Services (CMS), on July 1, 2013, CareFirst embarked on a pilot of the PCMH Program with over 40,000 Maryland residents enrolled in traditional Fee-For-Service (FFS) Medicare.

The PCMH program is the core of the larger TCCI program. The PCMH program was established for the purpose of rewarding primary care physicians (PCPs) for providing, arranging, coordinating, and managing quality, efficient, and cost-effective health care services for individuals enrolled in health benefit plans issued or administered by CareFirst. It provides the central organizational building block (the medical care panel – a group of 5 to 15 primary care providers working together for the purposes of the program) as well as the key incentive system built on a global outcome and member-centric accountability structure.
In all, there are 10 distinct but highly interrelated design elements in the PCMH program and 18 distinct additional interconnected components in the TCCI Program. The PCMH and TCCI Programs necessarily rely on all parts of the health care delivery system to deliver needed services to members. This includes hospitals, free-standing clinics, pharmacies and other allied providers that are part of the extremely large network of providers under contract with CareFirst as participating providers (over 43,000 providers are in CareFirst networks).

The PCMH Program seeks to build a sound foundation for longer term initiatives in primary care, continuous quality improvement and lower member use of high-cost hospital services. In so doing, the Program is intended to form lasting, stable partnerships among providers and CareFirst in the belief that this is essential to sustained improvements in quality and cost restraint.

A detailed description of the program and its components can be found at: www.carefirst.com/pcmhguidelines.
Appendix A-1

Grant Project Summary
Safety Net Patient-Centered Medical Home Initiative

CareFirst’s Safety Net Health Centers Patient-Centered Medical Home Initiative provided $7.2 million in grants to eleven health centers in Maryland, DC, and Northern Virginia to support implementation of patient-centered models targeting chronically ill and underserved populations. The projects extended from two to four years with individual grants ranging from $287,000 to $1.58 million. The majority of grantees report that the grant funds allowed them to transform the manner in which they deliver care. The experiences of the grantees mirror the patient-centered medical home research. The table below summarizes the grant projects, program outcomes, successes, and challenges.

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<th>Project</th>
<th>Project Summary</th>
<th>Successes and Challenges</th>
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| Arlington Free Clinic | The purpose of the grant was to transition AFC to a patient-centered medical home, allowing empanelment of all patients with serious and chronic health conditions. CareFirst’s support enabled hiring and training staff, improving internal processes, and improving internal and external communication. AFC hired Medical Assistants to complete the care team composed of a volunteer physician, Registered Nurse, and pharmacist. Grant funds also were used to implement disease registries, develop templates to measure health outcomes, create a mechanism to exchange patient data with community partners, and develop strategies to address and overcome health disparities. | successes:
  • More aggressive treatment of chronic disease as a result of EHR
  • Enhanced appreciation for care plans. challenges:
  • Integrating care plans into EMR
  • Difficulty engaging some patients in their care.
  • Educating staff and volunteers on PCMH model of care. |
| Baltimore Medical System | Grant was to assist in implementing a system of care that empowers primary care providers (PCP) to screen and treat chronically ill mental health patients by using social workers as intermediaries between the psychiatrist and PCP. The project design entailed behavioral health screening at all primary care visits and immediate referrals to a social worker for patients who scored outside the normal range on the screening tool. Patients with elevated behavioral health issues were identified and referred to a social worker for further assessment and intervention. | successes:
Primary care providers routinely screen for behavioral health issues challenges:
  • Staff turnover
  • Provider buy-in
  • Patient enrollment |
<table>
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<tr>
<th>Project Period: 3 years, 2 months</th>
<th>scores were referred for short-term or long-term interventions. The original design of this grant project was modeled after a program developed by the University of Washington promised to provide includes tools and systems. Internal issues at the institution precluded the delivery of program implementation and evaluation resources. Consequently, BMS was unable to deliver the robust evaluation outlined in their grant original proposal. Beyond the grant funding period, BMS primary care providers will continue to perform behavioral health screenings at all primary care visits.</th>
<th>• Adequate data collection and reporting system</th>
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<td>Project was extended 15 months</td>
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| Calvert Healthcare Solutions | Grant project supported targeting chronically ill uninsured and publicly insured adults receiving services in three hospital-affiliated primary care practices. Patients with diabetes, hypertension, and behavioral health issues received care coordination from an RN Case Manager hired with grant funds who supported primary care providers in the affiliated practices. Spanish-speaking patients were served using a Hispanic liaison. The grant also provided supplemental reimbursement to providers for related pharmaceuticals, specialist visits, and disease management classes. | Successes
• PCMH culture adoption by some staff members.
• Reduced patient costs, ED utilization, and admissions. Challenges
• Staff recruitment
• Patient recruitment |
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<tr>
<td>Grant Award: $287,762</td>
<td>Number Targeted: 176 Number Served: 190</td>
<td></td>
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<tr>
<td>Project Period: 2 Years, 8 Months</td>
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| Chase Brexton Health Systems | Funds were awarded to expand implementation of the HOPE (Healthy Outcomes through Patient Empowerment) Program, which promotes medication adherence among chronically ill patients with a history of non-adherence or who are at risk for non-adherence. | Successes
• Their hiring of a Patient Navigator to assist patients with adherence to medical appointments and medications was integral to their project enrollment success. |
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</thead>
<tbody>
<tr>
<td>Grant Award: $250,000</td>
<td>Targeted: 220 Served: 228</td>
<td></td>
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<tr>
<td>Project</td>
<td>Period</td>
<td>Grant Details</td>
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</tr>
<tr>
<td>Choptank Health System</td>
<td>3 Years</td>
<td>Project provided comprehensive diabetes education and care coordination for uninsured and publicly insured diabetics living in three rural counties in Maryland. Grant funds supported hiring two nurses and securing their AADE (American Association of Diabetes Educators) certification.</td>
</tr>
<tr>
<td>Community Clinic, Inc. (in collaboration with Greater Baden Medical Systems)</td>
<td>2 Years, 8 Months</td>
<td>Grant funds fully or partially supported employing a Patient Navigator, Clinical Pharmacist, nurses, MST Pharmacy Technician, and three Behavioral Medicine Clinicians. In addition to supporting medication adherence, the team identified and recruited patients, referred patients for ancillary services, and provided patient education.</td>
</tr>
<tr>
<td>Project Name</td>
<td>Award Amount:</td>
<td>Number Served:</td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td>Community Health Worker Coordination</td>
<td>$1,585,521</td>
<td>11,076</td>
</tr>
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<td></td>
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<tr>
<td>Health Care for the Homeless</td>
<td>$750,000</td>
<td>518</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>Mary's Center</td>
<td>$596,665</td>
<td>7,104</td>
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</tbody>
</table>

**Community Health Worker Coordination**

- Community Health Workers who provided care coordination and outreach. Grantee reports that grant funds were “transformational” in implementing the PCMH model of care.

**Health Care for the Homeless**

- Project aimed to implement a patient-centered medical home for homeless people by empaneling chronically ill patients to care teams. The project entailed hiring a physician and support staff to create a “prototype” care team to refine eventual clinic-wide implementation of the PCMH model.

**Mary’s Center**

- Project provided care coordination to patients with diabetes, hypertension, and asthma. Grant funds supported hiring of a nurse Care Coordinator and Panel Manager to monitor optimal implementation of the PCMH model. The project was enhanced by an electronic universal care plan that could be accessed in real time by all care team members.
<table>
<thead>
<tr>
<th><strong>Primary Care Coalition</strong></th>
<th>Project purpose was to implement the patient-centered medical home model in the practices of two coalition members, Holy Cross and Proyecto Salud. Funds supported hiring a Care Coordinator for each site and partially funding a Project Director who coordinated efforts and standardized operating procedures.</th>
<th><strong>Successes</strong></th>
</tr>
</thead>
</table>
| Award Amount: $599,514 | | • Improved biometrics in 70% of patients.  
• Strong interdisciplinary teams. |
| Project Period: 3 Years | | **Challenges** |
| Number Served: 488 | | • Staff recruitment and retention  
• Utilizing CRISP  
• Establishing PCMH culture. |

<table>
<thead>
<tr>
<th><strong>Total Health Care</strong></th>
<th>Project purpose was to implement the patient-centered medical home model in one of their nine health centers. Support fully or partially funded employing a Care Coordinator, Social Worker, Pharmacists, Outreach Workers, and Project Director.</th>
<th><strong>Successes</strong></th>
</tr>
</thead>
</table>
| Award Amount: $1,141,278 | | • Integration of primary care and behavioral health.  
• Culture change in care team.  
• PCMH will be expanded to other centers. |
| Number Served: 5,680 | | **Challenges** |
| Project Period: 3 Years, 6 Months | | • Integration of new EHR.  
• Establishing a PCMH culture. |

<table>
<thead>
<tr>
<th><strong>Unity Health Care</strong></th>
<th>Project purpose was to implement same-day and after-hour, walk-in clinics at two locations; launch a robust ED diversion project; and provide care coordination to chronically ill high-utilizers of the ED. Funds supported start-up expenses associated with opening the “Convenient Care” clinic and hiring staff to support ED diversion activities and outreach to chronically ill patients who were believed to not be engaged with a primary care provider.</th>
<th><strong>Successes</strong></th>
</tr>
</thead>
</table>
| Award Amount: $913,801 | | • 35% increase in show rate following ED Diversion Team contact  
• Anecdotal increased health literacy through education for ED diversion interventions.  
• Completed twice as many Convenient Care visits as anticipated |
| Number Served: 42,000 | | **Challenges** |
| Project Period: 3 Years | | • Large high-acuity and hard-to reach |
population challenged program resources.
  • Lack of access to claims data precluded calculating utilization and cost saving analysis.

<table>
<thead>
<tr>
<th>TECHNICAL ASSISTANCE AND CAPACITY BUILDING FOR TO GRANTEES</th>
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<tbody>
<tr>
<td><strong>Care Coordinators’ Roundtable</strong></td>
</tr>
<tr>
<td>The grant project created a learning collaborative</td>
</tr>
<tr>
<td>between the safety net Care Coordinators and Care</td>
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<tr>
<td>Coordinators from CareFirst. This group met periodically</td>
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<tr>
<td>via webinar to learn about emerging issues in care</td>
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<tr>
<td>coordination, share experiences, and group problem-solve</td>
</tr>
<tr>
<td>around issues brought to the collaborative.</td>
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<tr>
<td>Topics covered in the Care Coordinators’ Roundtable</td>
</tr>
<tr>
<td>included:</td>
</tr>
<tr>
<td>• The CareFirst Care Plan</td>
</tr>
<tr>
<td>• Care Coordination: The Benefits and Challenges</td>
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<tr>
<td>• What’s the Difference: Care Coordination v. Case</td>
</tr>
<tr>
<td>Management</td>
</tr>
<tr>
<td>• Maximize Care Team Roles</td>
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<tr>
<td>• Patient Engagement</td>
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<td>• Motivational Interviewing</td>
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<tr>
<td>• Care Coordination for Chronic Mental Health</td>
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<tr>
<td>Conditions</td>
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<tr>
<td>• Cultural Competence in Care Coordination</td>
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<tr>
<td>• Using Interpreter Services in Care</td>
</tr>
<tr>
<td>Coordination</td>
</tr>
<tr>
<td>• Information Technology Systems that Can Support</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td><strong>Grantee Capacity-Building Workshops</strong></td>
</tr>
<tr>
<td>Workshops were offered to grant project staff to expand</td>
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<tr>
<td>their learning in various areas that could support</td>
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<tr>
<td>enhanced implementation of their grant project.</td>
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<tr>
<td>Topics included:</td>
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<tr>
<td>• Health Literacy</td>
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<tr>
<td>• Program Planning</td>
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<tr>
<td>• Program Evaluation</td>
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<tr>
<td>• Developing a Work Plan</td>
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<tr>
<td>• Measuring Perceived Health Status</td>
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<tr>
<td>• Electronic Care Planning Tools</td>
</tr>
<tr>
<td>• PCMH Data Integrity</td>
</tr>
<tr>
<td>• Enrolling and Maintaining Caseload</td>
</tr>
</tbody>
</table>

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