

RESOLUTION 36 - 2010

Subject: CME for Medical Home Clinical Skills
Introduced by: Norman M. Jensen, MD
Referred to: Organization and Finances

1 Whereas, The Patient-Centered Medical Home is likely to become the re-incarnation of idealized
2 primary health care; and

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4 Whereas, The clinical skills needed for optimal function of a Patient-Centered Medical Home are
5 moderately well known, learnable, and teachable; and

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7 Whereas, The clinical skills needed for the optimal function of a Patient-Centered Medical Home
8 are likely new or underdeveloped for a significant number of members and non-members; and

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10 Whereas, There are readily available resources to facilitate the learning of those skills; and

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12 Whereas, There is ample evidence available that the skills when implemented result in several
13 highly desirable outcomes like patient health outcomes, patient and physician satisfaction, and
14 reduced grievance and malpractice claims; and

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16 Whereas, It is strongly hypothesized that the skills implemented will result in reduced cost
17 without loss of value; and

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19 Whereas, There is a high enough likelihood that this training would be a net revenue generator for
20 the Society that makes the relatively small risk worth taking; therefore be it

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22 RESOLVED, That the Wisconsin Medical Society will design and sponsor a regional program of
23 Patient-Centered Medical Home skills training for members and non-members.

Fiscal note: \$25,000 or greater for staff time or third party to design, depending upon the
extensiveness of the program to be developed. Meeting and related costs to sponsor
the training program.

Relevant Policies

**Society:
REQ-007**

Patient-Centered Medical Home: The Wisconsin Medical Society supports the Joint Principles of the Patient-Centered Medical Home developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association as guidelines for Wisconsin and all states to improve the health of its citizens. The Wisconsin Medical Society encourages Wisconsin to implement and fund pilot programs to demonstrate the quality, safety, value, payment mechanisms and effectiveness of the patient-centered medical home.

The Wisconsin Medical Society will put forward a resolution to the American Medical Association in support of the Joint Principles of the Patient-Centered Medical Home and to encourage national payors to implement

and fund pilot programs to demonstrate the quality safety, value, payment mechanisms and effectiveness of the patient-centered medical home.

Principles (2/07)

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 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. (HOD, 0408)

AMA:

H-160.919 Principles of the Patient-Centered Medical Home

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: 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 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. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. (Res. 804, I-08; CMS Rep. 8, A-09)

H-300.983 Community Hospital Continuing Medical Education

The AMA believes that quality, patient-centered, cost-effective continuing medical education is important for hospital medical staffs, and that the cooperative efforts of hospitals, state and county medical societies, and academic medical centers contribute to achieving this goal. (CME Rep. D, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)