| Participant Question | Ted Wymyslo's Response |
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| 1. Does Community Paramedicine play a role in the Minnesota medical home program? | N/A |
| 2. What is the prevention target? | Most of our regional measures are aligned with NQF and Hedis, so some emphasis on prevention, but more on process measures and screening efforts at the front end of PCMH expansion. The expectation is that once we have the infrastructure in practices to track data and performance, we can turn our attention to prevention strategies in alignment with the National Prevention Strategy. |
| 3. What is the magnitude of payment differential for best versus worse performance for a primary care practice? What proportion of the practices' patient population is eligible for P4P? | Payment for quality has not been universally implemented across Ohio yet. We are learning from the CMMI-CPCi effort in the Cincinnati region about what the ROI is to insurers when PMPMs are provided to pilot practices, with the first year report showing they are breaking even on the cost with savings in admissions. The rest of the state is largely still FFS, with all of Medicaid and contracts for healthcare to state health workers now designed to evolve into a payment for value design. |
| 4. I am curious, whether this effort has been prioritized using Health Professional Shortage Area (HPSA) information and score, that are calculated by Primary Care Offices in your states, and confirmed by the Health Resources and Services Administration--in determining where to put greatest attention in determining where to put attention in Ohio and Minnesota? | While our efforts encouraged participation by rural and urban practices, we instead placed an expectation on practices involved in our PCMH Education Pilot Demonstration project that at least 15% of the population they serve would be Medicaid and/or uninsured, as we were using CHIPRA funds to train the 42 practices in PCMH. Around the state, the major drivers of transformation to PCMH have been the private health systems, who have done the funding. Many of our FQHCs in the state took advantage of available federal incentives to get to PCMH recognition level. |
| 5. Bonnie, who hires and funds the site visitors? | N/A |
| 6. We have focused today on the medical home, but what about the medical neighborhood and progress in advancing that model? | By first focusing internally on the development of capacity in the practice to function as a coordinator of patient care, the stage is set to then connect to the medical neighborhood and community surrounding the PCMH practice. Going beyond the walls of the medical office is a critical next step to addressing the total health needs of the patient. |
| 7. What are the next steps for primary care practices after they have achieved PCMH recognition? | Becoming high performance organizations is the next step. That means they need to not only focus on producing high quality outcomes, but also be sure that is done in a sustainable manner by considering costs incurred. Efficiency, staffing needs, equipment costs and utilization, and other operational issues become a bigger part of the conversation to allow achievement of the triple aim by the practice. |

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| 8. How does the PCMH model fit with efforts to form ACOs? | Becoming a PCMH is the foundation work for next evolving into an ACO. Most practices must have the ability to coordinate and manage patient populations that the PCMH model incorporates in order to be a valued partner in an ACO. |
| 9. Is payment reform making the PCMH model sustainable in your state? | |
| 10. How else can public health be more engaged with primary care efforts at transformation? | Incorporating public health information into the clinical office setting is the next major step to achieve meaningful integration. Public health geomapping and data sharing should be available to the clinician for use at the bed-side to benefit clinical decision support and personal plan of care formulation. |