MARYLAND ACADEMY OF
FAMILY PHYSICIANS
ABLE, RESPONSIVE FAMILY PHYSICIANS SERVING THEIR COMMUNITIES

To: Maryland Department of Health and Mental Hygiene

Re: Draft Maryland State Health System Innovation Plan

As President of the Maryland Academy of Family Physicians (MDAFP), I offer these comments regarding the draft version of the Maryland State Health System Innovation Plan, referred to below as The Plan.

The Plan lists many important, overlapping, and complementary initiatives. Two initiatives described in The Plan that will affect primary care practices to a large extent are the proposed Duals ACO and the Maryland Comprehensive Primary Care Model.

MDAFP is pleased that the State proposes to make these investments in primary care in order to improve health outcomes for vulnerable patients and to help Maryland succeed in meeting the challenges of the All Payer Model. And here we insert our advice, which is informed by our experience of PCMH programs and ACOs in general:

It can be difficult to recruit and engage primary care physicians (even those that are employed) in these programs without certain elements in place and without certain principles being maintained. We have learned that the promise of shared savings is not enough. And added burdens to our workflows makes us less likely to adopt programs. There are, however, elements of success that are common among programs with high provider adoption and engagement. These elements are summarized below:

Ideally a primary care-based care improvement program should:

1) Be voluntary, yet substantially more appealing than status quo, and thus attractive to a broad range of primary care clinicians

2) Be sustainable, because the program measurably improves patient-centered outcomes and population health, including reducing disparities in care delivery and outcomes

3) Be inclusive of all payers and patients (realizing that this may take time)

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4) Allow for regional customization to fit local population and infrastructure needs

5) Involve practicing clinicians in its design, implementation and governance - this is critical because the hard work of care transformation takes place at the practice level. Pick leaders for the programs who will live with the decisions they make and experience the changes in workflows themselves.

6) Provide primary care practices with resources, or access to resources (e.g. care management, reporting, field support)

7) Shorten the interval between success and reward

8) Decrease or eliminate the need to maintain high practice visit volumes in order to meet overhead by, for example, providing risk-adjusted PMPM payments that are not linked to visits - we see this is proposed for both Duals ACO and MPCP models

9) Develop a universal, small set of quality and utilization metrics that are a) meaningful to us and our patients and b) gathered and reported at minimal to no burden on the practices

10)Decrease or eliminate patient consent requirements and reporting burdens of practices by providing centralized administration and other data services through CRISP

11) Provide real-time feedback to individual physicians regarding performance

12) Foster alignment with other non-primary care docs and non-medical providers, across the continuum of care - this is true care transformation

13) Eliminate existing, low-value regulations that impede efficiency in care, e.g. the 3-day stay.

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14) Promote role satisfaction in primary care in order to decrease burn out and drop-out in our workforce, and attract new physicians to primary care. Instead of adding to workflow of physicians, create new workflows that lessen administrative burdens on docs.
Thank you again for the opportunity to comment on The Plan.

Sincerely,

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