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Medical Home NEWS

The Nurse-Managed Health Center as a Medical Home

By Tine Hansen-Turton, MGA, JD, Executive Director, Convenient Care Association, and Ann Ritter, Esq., Director of Health Center Development and Policy, National Nursing Centers Consortium

Diane Gass is a grandmother who lives alone in a public housing development in North Philadelphia. Before a nurse-managed health center opened in her public housing development in 1995, asthma attacks and diabetes complications would send Ms. Gass to the emergency room *up to five times every month*. She credits the services provided by her nurse-managed health center with significantly improving her health. In 2008, Ms. Gass reported, "I haven't been to the hospital in God knows how long on account of the clinic. That clinic saved my life."[1]

In recent years, Pennsylvania has encouraged the growth of nurse-managed health centers like this one in urban, rural, and suburban communities throughout the state. Three nurse-managed health center networks in Southeastern Pennsylvania have been selected to participate in the first phase of the Pennsylvania Chronic Care Initiative, a groundbreaking policy-driven initiative to encourage the spread of the medical home model in primary care practices throughout the Commonwealth. These nurse-managed health centers serve well over 20,000 unique patients annually, and have been recognized by the Governor's Office of Health Care Reform for their outstanding performance.

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In This Issue

It Takes a Village to Build a Medical Home

By Christopher Crow, MD, MBA, Founder of Legacy Medical Village and Co-Founder and Family Physician for Village Health Partners

When it comes to healthcare, today's debate centers on the providers and the regulators. Insurance companies and healthcare giants dominate the conversation and demand most of the attention. However, the most important voice missing from the discussion is the patient.

While they are often neglected as a major impetus for healthcare reform, patients are why our industry exists. The patients' needs ultimately fuel our business, not insurance companies or the government.

So, what if a key piece to solving the healthcare puzzle is simply to offer patients convenient access to the best quality medical care? That was the question that led to the founding of Legacy Medical Village, a one-stop healthcare facility, located in Plano, Texas. The state-of-the-art facility houses more than 20 medical practices and ancillary facilities with award-winning physicians who offer comprehensive care.

A Better Healthcare Experience

The "medical village" concept was created as a community solution to healthcare with primary care (in this case, a family medical practice called Village Health Partners) as the entry point for patients and foundation of the concept. Village Health Partners is a nationally recognized practice that focuses on quality, access and convenience for its patients by utilizing health information technology to enhance the outpatient care experience.

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[1] J. Goldstein, "Helping patients help selves - Pa. panel aims to transform chronic -care delivery," *THE PHILADELPHIA INQUI*RER, February 13, 2008, page A1.

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Editor's Corner

Raymond Carter, Editor, *Medical Home News*

As announced last month, I have invited members of the *Medical Home News* Advisory Board to submit short op ed pieces for inclusion in this space. You will see their submissions here from time to time. Other *Medical Home News* readers are welcome to submit commentary as well.

For this month, however, I am delighted to introduce a new member of the *Medical Home News* Advisory Board, Jeanne McAllister. *Ed.*

Jeanne McAllister, BSN, MS, MHA
Director, Center for Medical Home Improvement and Consultant, Medical Home Initiatives, Crotched Mountain Foundation
Greenfield, NH

Jeanne W. McAllister is Director and Co-Founder of the Center for Medical Home Improvement (CMHI), Crotched Mountain Foundation, Concord, NH. She is also an Adjunct Associate Professor of Psychiatry & Pediatrics at Dartmouth Medical School. Her work with the community-based primary care medical home began in 1994 and spans CMHI's validated Medical Home Index, pilot and demonstration efforts, outcome studies, a care coordination framework, and now CMHI's Medical Home TAPPP™ (Gap) Analysis tool which provides a road map for practice transformation. Among other publications, she is the lead author of a *Pediatrics* article titled "Practice-Based Care Coordination: A Medical Home Essential" and its accompanying implementation workbook.

She provides consultation to a variety of medical home efforts both locally and nationally. She has developed numerous practice-based materials and published articles on the medical home, transformation, and care coordination. Ms. McAllister brings over twenty-five years experience in health care and blends her clinical, educational, policy, and administrative preparation to promote the patient and family centered medical home across the lifespan.

Ms. McAllister received her Bachelor of Science in Nursing (BSN) degree from the University of Vermont; a Masters of Health Science Education (MS), Health Professions Education from the University of Pennsylvania; and a Masters of Health Administration (MHA) degree from the School of Health and Human Services, University of New Hampshire. She was the featured "Catching Up with…" profile in the October 2009 issue of *Medical Home News*.

Is there an article you particularly liked? Or perhaps disagreed with? A topic you haven't seen covered but think we should pursue? Let us know. We would like to see this section of *Medical Home News* grow into a commentary and suggestion segment. Remember, you can also receive each issue of *Medical Home News* via email in an electronic PDF version, via regular mail in print version, or both. Should you wish to confirm or change your delivery option, feel free to contact us at any time at www.MedicalHomeNews.com.

Who Will Provide Primary Care and How Will They Be Trained?

An Excerpt from a Josiah Macy, Jr. Foundation report

In January 2010 the Josiah Macy, Jr. Foundation convened a conference to address complex issues concerning who will provide primary care and how they will be trained. The conference co chairs were Linda Cronenwett, Ph.D., R.N., FAAN, Professor and Dean Emeritus, School of Nursing, University of North Carolina at Chapel Hill, a and Victor J. Dzau, M.D., James B. Duke Professor of Medicine, Chancellor for Health Affairs of Duke University and Chief Executive Officer of the Duke University Health System. Forty-seven other experts in primary care issues from around the country joined five Macy Foundation staff in Durham, NC for the event. An executive summary of the process and meeting is included in an interim report available through the foundation's web site (see full citation below). A more comprehensive monograph is also planned. Following are major conclusions and recommendations that emerged from the conference.

CONCLUSION I

In order to meet societal needs for primary care and train the right primary care professionals in the right numbers with the right competencies for the most appropriate roles, healthcare systems need incentives to dramatically change the way primary care is valued, delivered, and integrated in evolving healthcare systems. We will not attract and retain sufficient numbers nor achieve the needed geographic distribution of primary care providers unless there is a greater proportional investment in primary care. Our students and trainees must be educated throughout their clinical training in practices that deliver first-contact, comprehensive, integrated, coordinated high-quality, and affordable care. These practices require teams of professionals who give care that elicits patient and provider satisfaction under conditions of clearly defined roles, effective teamwork, patient engagement, and transparency of outcomes.

Recommendation 1: Create financial and other incentives for the development of innovative models of primary care and the advancement of knowledge about outcomes that allow us to identify best practices in the achievement of high-value primary care. Strategies may include the following:

- A competitive process for the establishment of Centers of Excellence in Primary Care
- Mechanisms that analyze and better define the roles of various health professionals in best- practice, high-value primary care models
- Development and improvement of national metrics for assessment of patient and population health
- Mechanisms for the diffusion of knowledge about best practices, such as the proposed Primary Care Extension Program.

Recommendation 2: Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes.

Recommendation 3: Promote stronger ties between academic health centers and other primary care sites and the communities they serve, setting goals and standards for accountability for primary prevention as well as individual and population health. All health systems, including the primary care practices embedded within them, should be accountable for quality and cost outcomes through well-tested, nationally recognized metrics that address the needs of populations and individuals, with data that are transparent and that can be used for the continuous improvement of models of care.

Recommendation 4: Invest in primary care health information technologies that support data sharing, quality improvement, patient engagement, and clinical care, with the aim of continuously improving the health and productivity of individuals and populations.

Recommendation 5: Recognizing that current payment systems create incentives for under investing in primary care services, implement all-payor payment reforms that more appropriately recognize the value contributed by primary care through such mechanisms as global payments linked to patient complexity and accountability for the provision of healthcare services, including preventive services, care coordination across settings, chronic disease management, and 24/7 accessibility. Improved costs and quality of health outcomes for patients and populations should be rewarded. In addition, implement legislation that will standardize insurance reimbursement reporting requirements to reduce administrative costs inherent in a multi-payor system.

CONCLUSION II

In addition to the critical challenges outlined above in the organization and financing of healthcare, current health professional educational models are generally inadequate to attract, nurture, and train the primary care workforce of the future.

Recommendation 1: Create incentives for innovative projects in health professions education, enlisting funding partners from government, industry, philanthropy, and payors in order to develop models of excellent, high-performing, and advanced inter-professional primary care. Academic health centers, working with teaching community health centers, area health education centers (AHECs), and other training sites are the logical entities to advance such innovations.

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Who Will Provide Primary Care and How Will They Be Trained?...*continued*

Strategies could include the development of Primary Care Translational Centers of Excellence that would perform primary care research and evaluation and provide team-based education, with emphasis on the study of new models of primary care and health delivery transformation.

Recommendation 2: Medical schools, nursing schools, and other schools for the health professions, which hold the societal responsibility for the education of health professionals, have an opportunity and obligation to increase the size and strength of the primary care workforce. Leaders of health professional schools should implement actions known to increase the number of students and trainees choosing careers in primary care. These actions include the following:

- Establishing programs to prepare and attract a more socioeconomically, racially, and geographically diverse student body
- Revising admission standards to include more emphasis on social science and humanities and the personal qualities of applicants
- Implementing and expanding scholarship and loan repayment programs in partnership with health systems, governmental agencies, and communities for those pursuing careers in primary care
- Promoting early exposure to primary care practices for all students
- Creating longitudinal immersion clinical experiences in community primary care settings
- Implementing special primary care tracks for students and trainees.
- Establishing and strengthening departments of family medicine within schools of medicine.

Recommendation 3: Inter-professional education should be a required and supported part of all health professional education. This change is especially important for primary care. Regulatory, accreditation, reimbursement, and other barriers that limit members of the healthcare team from learning or working together should be eliminated.

Recommendation 4: The Department of Health and Human Services, through its appropriate agencies and divisions, should be granted additional funding to support inter-professional training, preparation of the primary care workforce, and leadership development programs to produce clinicians to take the lead in new models of primary care. Strategies to accomplish these goals could include the following:

- Expansion of Title VII and Title VIII funding and authority to jointly fund interprofessional programs
- Expansion of Title VII and Title VIII funding to address faculty shortage and educational underinvestment in the development of faculty for primary care
- Increase in AHEC funding to expand its pipeline programs in primary care and to provide community-based, interprofessional educational experiences for all primary care health professions students
- Resumption of the Primary Care Health Policy Fellowship and creation of new programs to prepare clinician-leaders for new models of practice
- Provision of adequate scholarships and loan repayment programs to provide clinicians to underserved areas and to improve diversity
- Expansion and direction of funding for graduate medical, nursing, and physician assistant educational programs (Medicare Graduate Medical Education funding, Title VII, Title VIII) to support trainees and training infrastructure costs in ambulatory settings, including teaching community health centers, AHECs, academic outpatient clinics, and other community-based programs.

CONCLUSION III

Recognizing that the healthcare system is dynamic and will continue to evolve, strong leadership will be needed to advance the science, teaching, practice, and policy development relevant to primary care.

Recommendation 1: Develop leaders with a focus on advancing the curricula and learning opportunities for preparing competent primary care clinicians, scientists, and policymakers of the future. Medical, nursing, and other health profession school faculties should form partnerships with educators from other disciplines, such as business and law, to develop novel educational opportunities for advancing primary care leadership, research, policy, and advocacy. As a routine part of their education, primary care students should be exposed to mentored opportunities to participate in healthcare improvement and policy development and to function within inter-professional and interdisciplinary leadership teams.

Recommendation 2: Support the further development of science and the scientific leadership necessary to advance the translation of best practices into primary care delivery for the improvement of patient and community health. Initiatives could include the following:

- Funding career development for scientists that can create improved national metrics for assessment of individual and population health
- Providing targeted funding through Clinical Translational Science Awards, National Research Service Awards, and Health Research Services Awards for scientists focused on primary care
- Developing a national healthcare workforce analysis and policy capability for ensuring an adequate and well-prepared primary care workforce over time.

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The Nurse-Managed Health Center as a Medical Home *…continued*

In nurse-managed health centers throughout the country, nurse practitioners work with an interdisciplinary team of health professionals to provide comprehensive primary care and wellness services to patients. As the name suggests, advanced practice nurses (primarily nurse practitioners) lead these innovative and cost-effective health centers. They are one part of a larger movement, driven by a shortage of primary care physicians, to increase practice opportunities for nurse practitioners in the non-profit, public and private sectors. There are already more than 140,000 nurse practitioners in the U.S. practicing in these and other settings such as community health centers, hospital-based clinics, and group practices, and this number is expected to grow at a faster annual rate than any other type of primary care professional in coming years (compared to physicians, dentists, and physician assistants).[2]

In 2006, Governor Edward G. Rendell launched an ambitious health reform plan to increase access, reduce costs, and improve health care quality. As part of this effort, the Governor created the *Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission*. This Commission developed a strategic plan to improve chronic care that led to the creation of the Pennsylvania Chronic Care Initiative. This Initiative would recruit primary care practices to participate in a series of learning collaboratives and receive enhanced reimbursement for adopting aspects of Wagner's Chronic Care Model.[3]

In keeping with Governor Rendell's priority to increase the utilization of nurse practitioners and other non-physician providers, Pennsylvania decided to open up its medical home project to health centers led by nurse practitioners and other advanced practice nurses. Although nurse-managed health centers exist in 40 states, Pennsylvania is in many ways the national leader in nurse-led care. Southeastern Pennsylvania in particular has a strong tradition of nurse-led practices, with a number of respected nurse-managed health centers located in or near Philadelphia. Given Governor Rendell's policy priorities, it seemed natural to include nurse-managed health centers as participating practices in the first round of the Pennsylvania Chronic Care Initiative. Together with physician-led practices from the region, these nurse-led health centers worked to improve care for their patients with chronic diseases. "The process of refining the way we provide care has been challenging at times but always valuable," said Nancy Rothman, RN, EdD of the PHMC Nursing Network, which has four nurse-managed centers participating in the Chronic Care Initiative. "We've been very happy to have the opportunity to learn from and share information with physician and nurse colleagues about what works and what doesn't work when it comes to caring for patients with chronic illnesses."

Nurse-managed health centers are prime candidates to participate in medical home initiatives.[4] Nurse practitioners are capable of providing high-quality primary care with similar patient outcomes to physicians.[5] Patients of nurse-managed health centers have an ongoing relationship with a nurse practitioner that provides first contact and continuous, comprehensive primary care. In addition, a federally-funded evaluation compared quality measures among nurse-managed health centers in Pennsylvania and similar providers (e.g. physician-managed safety-net health centers) found that nurse-managed health centers experienced higher patient retention rates, and nurse-managed health center patients expressed a high level of satisfaction with the care provided.[6] Results also showed that nurse-managed health center patients experienced higher rates of generic medication fills and lower hospitalization rates.[7]

Nurse-managed health centers' participation in the Pennsylvania Chronic Care Initiative has not been without controversy. To qualify for enhanced reimbursement under the Chronic Care Initiative, participating primary care practices must achieve recognition through the National Committee on Quality Assurance's (NCQA) *Physician Practice Connections*® – *Patient-Centered Medical Home*™ product line.[8] This requirement is meant to ensure that participants implement practice changes to improve quality of care. There are three levels of recognition that can be achieved through the product line, all of which qualify practices for enhanced reimbursement from payers and the Commonwealth.

None of the specific elements contained in NCQA's Patient-Centered Medical Home product are beyond the reach or scope of a nurse-managed health center. The nurse-managed health centers participating in the initiative have implemented many of these elements successfully. However, NCQA has stated that it will not recognize these nurse-led practices as Patient-Centered Medical Homes, because the product line only recognizes physician-led practices. Instead, NCQA has issued letters to nurse-managed health centers indicating that they have met the standards associated with Patient-Centered Medical Home status. However, unlike physician-led practices that have fulfilled the same elements, these nurse-led practices are not permitted to say that they have been recognized as Patient-Centered Medical Homes by NCQA.

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[2] Statement of A. Bruce Steinwald, Health Care Director, United States Government Accountability Office, Testimony Before the U.S. Senate Committee on Health, Education, Labor and Pensions, February 12, 2008. Available here: http://www.gao.gov/new.items/d08472t.pdf.

[3] More information about the Governor's Chronic Care Initiative is available here: http://www.rxforpa.com/chroniccare.html.

[4] K. Fiandt, *The Chronic Care Model: Description and Application for Practice*, MEDSCAPE TOPICS IN ADVANCED PRACTICE NURSING 6(4) (2006).

[5] M. Mundinger, *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians*, JAMA, 2000.

[6] T. Hansen-Turton, *The Nurse-Managed Health Center Safety Net: A Policy Solution to Reducing Health Disparities*, NURSING CLINICS OF N. AMERICA, 2005.

[7] Id.

[8] More information on this product line is available here: http://www.ncqa.org/tabid/631/Default.aspx.

The Nurse-Managed Health Center *…continued*

PHMC Health Connection, the nurse-managed health center in North Philadelphia where Diane Gass receives care, has been participating in the Pennsylvania Chronic Care Initiative since its inception and recently received a letter from NCQA stating their results on the survey tool "would be equal to Level 1 NCQA recognition" for PPC-PCMH. The letter from NCQA also noted: "As you are aware, NCQA does not formally recognize Nurse Practitioner led practices at this time. However, the final results will be reported to your sponsoring organization."

> … the Governor's Office of Health Care Reform has indicated that enhanced reimbursement will be made available to nurse-managed health centers that fulfill the elements of NCQA's Patient-Centered Medical Home product line, even if NCQA will not officially recognize them.

Recognizing that this policy unfairly disadvantages the nurse-managed health centers that participate in the Chronic Care Initiative, the Governor's Office of Health Care Reform has indicated that enhanced reimbursement will be made available to nurse-managed health centers that fulfill the elements of NCQA's Patient-Centered Medical Home product line, even if NCQA will not officially recognize them.

Despite some remaining barriers to full recognition of their role as primary health care providers, advanced practice nurses are nevertheless on the frontlines of the medical home movement, along with physicians. Diane Gass' success is an example of how nurse-led practices can improve primary care for patients with chronic illnesses. Creating a nurse-led primary care center in a community where residents have limited access to physicians was the first step to ensuring access to care for un- and underinsured people. Her providers also took a patient-centered approach to her care, a hallmark of the medical home model. Her primary care provider learned about her many pets at home, advised her on their impact on her asthma and referred her to the center's outreach staff. An outreach worker came to her home and gave her guidance on how to reduce asthma triggers in her home.

The advanced practice nurses who lead nurse-managed health centers understand that the health of each patient is in part a product of their physical, social, and economic environments. They also recognize the importance of working together with an interdisciplinary team of health professionals (including medical assistants, health educators, social workers, registered nurses, collaborating physicians, and others). Together, Ms. Gass and her nurse-led primary care team were able to get her chronic conditions under control. She no longer faces the daily specter of wondering if she'll be spending yet another day in the emergency room. While this kind of care is routine for nurse-managed health centers, Ms. Gass credits them with literally saving her life.

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Ann Ritter can be reached at aritter@nncc.us.

Who Will Provide Primary Care *…continued*

Recommendation 3: Recognize the need to include representatives of all primary care providers in the leadership of delivery systems and in groups that are responsible for developing healthcare policies at the state and federal level.

NOTE: The full citation for this report is: *Cronenwett L & Dzau V. Chairman's Summary of the Conference. In: Culliton B, editor. Who Will Provide Primary Care and How Will They Be Trained?, 2010; Durham, NC. Josiah Macy, Jr. Foundation; 2010.* This summary report is in the public domain and may be cited with attribution. Copies may be obtained directly from the Josiah Macy Foundation web site: www.josiahmacyfoundation.org.

It takes a Village to Build*…continued*

The family medical practice is complemented by open access to convenient services and specialty practices including a full-service laboratory, imaging, physical therapy and rehabilitation, skin center and sleep center. Together, they offer a seamless, cost-efficient and convenient approach to healthcare.

> The family medical practice is complemented by open access to convenient services and specialty practices including a full-service laboratory, imaging, physical therapy and rehabilitation, skin center and sleep center.

Dr. Lewis Frazier from Tarpon Orthopedics and Sports Medicine has been a part of Legacy Medical Village since its inception. He has found that his patients benefit on a daily basis from the relationship between primary care and specialty at Legacy Medical Village.

"For years the healthcare industry has been looking for a solution to provide better medical care," said Dr. Frazier. "Legacy Medical Village is the answer to our fractured healthcare system and provides access, convenience and quality of care all under one roof."

Healthcare When You Need It

Today's patients should be viewed more as consumers who want to get what they need, when they need it. Patients will often call their doctor's office wanting to be seen immediately, only to find that they are unable to get in that day. At Legacy Medical Village, patients are seen on the same day that their healthcare need arises.

Should a referral or additional services be necessary, patients can simply walk down the hall to the lab or the specialist, instead of making an appointment for another day. Additionally, the facility offers evening and weekend hours for acute care services to accommodate working families and busy schedules. Legacy Medical Village breaks down barriers that often deter patients from receiving the care they need.

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It takes a Village to Build*…continued*

The Solution

The medical village puts the patient at the center of the healthcare solution by streamlining their healthcare services and building a strong foundation, linking primary care with commonly used specialty services. This is similar to the one-stop shopping and convenience consumers have become accustomed to.

Legacy Medical Village has been recognized for its outstanding patient treatment which starts with superior primary care. Village Health Partners' quality of care exceeds clinical benchmarks and national standards, earning the "Practice of the Year" title in 2006 by America's leading practice management journal, Physicians Practice. Additionally, Village Health Partners was one of the first primary care groups in Texas to earn the Diabetes Physician Recognition Program (DPRP), developed by the National Center for Quality Assurance (NCQA) to recognize physicians who use measurement tools to provide excellent diabetes care.

Village Health Partners has used Electronic Medical Records (EMR), which only 17 percent of U.S. physicians and about 8-10 percent of U.S. hospitals have in place, and this has contributed to significant improvements in quality of care. The practice implemented an EMR system in 2003 and is now a U.S. show site for GE's Centricity healthcare program. Additionally, the practice has experienced improvements above the national average in quality of care, operational efficiency and ROI. This includes increased productivity and improved customer services as Village Health Partners now has a 3 to 1 employee-to-patient ratio versus the national average of 5 to 1.

The following chart demonstrates specific metrics on the quality of care patients receive at Village Health Partners, compared to national averages.

Preventative Measures		
	Village Health Partners	GE National Network
Diabetes Patients Receiving Eye Exams	51%	30%
Women Aged 50-69 Receiving Mammograms	72%	48%
Patients Aged 50 and Older Receiving Colon Screenings	58%	45%
Patients Receiving Blood Pressure Screenings	94%	82%

Village Health Partners offers a variety of convenient online services including a secure Web portal where patients can obtain prescription refills, schedule appointments, obtain test results and referrals, view allergy and medication history and submit billing questions. The practice also offers patients the option to sign up to e-mail non-urgent medical questions to their physician.

The medical village concept is one solution to a flawed system predicated on rising healthcare costs and a lowered quality of patient care. The medical village embodies the core pillars of the medical home, as it centers on the patient's needs.

Dr. Christopher Crow is the founder of Legacy Medical Village and co-founder and family physician for Village Health Partners. He can be reached at 972-599-9600 or by email at info@legacymedicalvillage.com.

*T*hought Leader's *C*orner

Each month, *Medical Home News* asks a panel of industry experts to discuss a topic of interest to the medical home community. To suggest a topic, send it to us at info@medicalhomenews.com.

Q: "What do we not know enough about with regard to the medical home model that you would want to have tested in a robust research and evaluation agenda?"

"Other than not knowing whether the Medical Home causes any consistent reduction in claims expense, we really don't know enough about its fit with the other ingredients that comprise health reform. How should an insurance benefit be configured to support the Medical Home? What electronic record 'meaningful use' criteria offer sufficient support? Should provider reimbursement be tilted in favor of the outcomes purportedly associated with the Medical Home, and should it be remitted as 'pay for performance' or as 'capitation'? How can the Medical Home reduce disparities? What is the role of distance telephonic coaching? In addition, I seriously doubt the Big Question on fitting these together can be answered using the 'robust research'(read high dollar) methodology typically favored by many of my policy and grant-addicted colleagues. There are far too many moving parts to fit in a reductionist single-variable environment, especially in non-generalizable settings favored by the academic research industrial complex; we also need to learn more about other evaluation approaches that trump locality, private practice, community hospitals and regional managed care insurers."

Jaan E. Sidorov, MD, FACP
Author, Disease Management Care Blog
Independent Health Care Consultant
Harrisburg, PA

"Although evidence suggests many of the medical home components may improve quality, cost, and patient and provider satisfaction, we still need to test the package of medical home capabilities rigorously to guide how best to achieve these goals. As I look around at the many demonstrations and pilots springing up, I am concerned by how many have very weak evaluations in place, or none at all. Providers and payers are making large investments in the model. We owe it to them and to patients to determine what the necessary and sufficient features are for improving care, so that the potential benefits of medical homes for patients are realized as cost-effectively as possible. We also need to draw on existing studies to ensure that medical home practices focus their more intensive efforts on the patients who really need and will benefit from them."

Debbie Peikes, MPA, PhD,
Senior Researcher, Mathematica Policy Research
Visiting Lecturer, Woodrow Wilson School, Princeton University
Princeton, NJ

"What we don't know enough about is the notion of the Journey as the major hallmark of a practice that is a truly functioning PCMH. It is that fact that the practice has reached a point where they understand that from now on they have to grow daily and improve in meeting the needs of their patient -- to be centered on the patient. They have to ask themselves in a process of continuous improvement -- are they meeting the behavioral health/mental health needs of the population they serve? Are they engaging the patient in a true partnership? They have to ask themselves every day what resources and or tools they need to link into virtually or build into the practice to meet their patients' needs?"

Paul Grundy, MD, MPH, FACOEM, FACPM
Global Director of Healthcare Transformation, IBM
Chair, Patient Centered Primary Care Collaborative (PCPCC)
Hopewell Junction, NY

"We do not know what elements of the Medical Home model produce better outcomes. Many groups are implementing elements of the model in hopes of improving care. How much do teams matter over care just by the physician? How important is online communication and care coordination? What HIT elements are the most important, such as Registry, EHR and patient portals? Do personal health records (PHRs) matter? All of these elements should be studied."

Joseph E. Scherger, MD, MPH
Vice President for Primary Care, Eisenhower Medical Center
Clinical Professor, Family Medicine, University of California, San Diego
Rancho Mirage, CA

*T*hought Leader's *C*orner

"I think the key questions we hope to have answered by our testing and evaluation of the Medicare medical home/advanced primary care practice demonstrations are the following:

1) How do practices defined as medical homes differ from practices not so defined? And what do such medical home practices do vis-à-vis the care of their patients that is different from what other practices do? How different is a medical home from a 'usual source of care'?
2) How do the patients treated in practices defined as medical homes differ from the patients treated in practices not so defined? How do the beneficiaries who actually enroll in the medical home demonstrations differ from the beneficiaries who don't?
3) Does the designation of a practice as a medical home change the quality, outcomes and utilization of patients treated in the practice over time and relative to the quality, outcomes and utilization of similar patients treated in other practices?
4) Does the medical home model address the problems of fragmentation, lack of coordination, avoidable hospitalizations, and high costs associated with the relatively small fraction of Medicare beneficiaries who account for the bulk of program spending?"

Linda M. Magno, MPA
Director Medicare Demonstrations Program Group
Centers for Medicare & Medicaid Services
Baltimore, MD

"Whether it actually saves money. Since the North Carolina Medicaid results are now fully discredited, there is no indication that a network-based model (as opposed to a "tight" model) saves money. This seems to be the same growing pains that the disease management industry went through, where early massive claims of savings discredited the field once they were revisited by more disinterested and sophisticated researchers. Another red flag is that the AAFP is essentially telling doctors to upcode. http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html. I know of no legitimate health care initiative which starts with advice to upcode and ends up saving money. So I would like to see a test by researchers who do not have a stake in the outcome and who have a background not in pharmacoeconomics or actuarial science but rather care management outcomes evaluation. At a minimum, people who have passed the Disease Management Purchasing Consortium's Critical Outcomes Report Analysis test."

Al Lewis
President, Disease Management Purchasing Consortium International, Inc.
Founder and Past President, Disease Management Association of America
Wellesley, MA

"One of the aspects of the medical home that could use more evaluation are the possible business models that would facilitate small and medium sized practices to 'sub-contract' some of the activities to third parties without breaching some state laws on the corporate practice of medicine. We also need more research on how to engage the patients and their families to help coordinate care. For example, cell phone text messaging and social networking text messaging."

Salvatore Volpe, MD, FAAP, FACP, CHCQM
Solo Practitioner
NCQA Level 3 Recognition - PPC®—PCMHT
Chairman of MSSNY HIT Task Force
Staten Island, NY

Medical Home Book of the Month

Medical Home Case Studies: Profiles in the Patient-Centered Approach documents experiences on the adoption, organization, delivery, funding, and outcomes of the medical home model. This 100-page special report profiles 11 healthcare organizations as they explore the benefits, opportunities, and challenges of the PCMH model from the viewpoints of payor, hospital, physician, nurse practitioner, case manager, and C-suite executive. http://store.hin.com/product.asp?itemid=3974

INDUSTRY NEWS

New Maryland State PCMH Program Proposed

Maryland Governor Martin O'Malley has asked the legislature to pass new legislations establishing a framework for the state to develop patient centered medical homes (PCHM), in part to provide a state action exemption that would protect health plans and providers from federal anti-trust challenges.

Under his proposed legislation the Maryland Health Care Commission (MHCC) would establish state-sanctioned PCMH programs. The MHCC-established programs would include both all-payer and single-payer pilots.

Last year, the Maryland Health Quality and Cost Council adopted a plan to launch an all-payer PCMH program composed of 50 practices, 200 providers, and up to 200,000 patients beginning in January 2011. Currently there is an11-practice pilot established a year ago by CareFirst.

Under the existing state insurance code, health plans can offer incentive payments to providers based on quality metrics. The Governor's proposal would extend that authority to care coordination payments and incentive-based bonus arrangements for providers participating in the new Maryland PCMH program. Plans could also share patients' medical information with patient consent.

Dayton Debate over APN-Led PCMHs

A state bill to support development of patient-centered medical homes in Dayton, Ohio was temporarily stalled over concerns from the state's physician community regarding medical homes being led by advanced practice nurses (APNs)

The debate over House Bill 198 was finally resolved when the bill's co authors agreed that four of the 40 primary care practices in the pilot program would be APN-led medical homes. Ten of the remaining 36 physician practices would be affiliated with Wright State University's medical school in Dayton. The State Association of Advanced Practice Nurses is pleased with the initial compromise but still concerned that only three of the 12 members of the proposed project advisory board would be APNs. The overall project still requires an appropriation to provide start-up finding to assist practices in the PCMH development process. The State Academy of Family Physicians is reserving judgment on the bill.

Smoky Hill Revisited

The May 2009 issue of *Medical Home News* featured an article on the new family residency program of the University of Kansas School of Medicine-Wichita Smoky Hill Family Medicine Residency Program in Salina, Kansas, aka Smoky Hill, begun earlier in the year. A year later, the group has assessed its progress in integrating the medical home model into its residency program.

continued

Smoky Hill Revisited…continued

One of the biggest accomplishments was the creation of what they have called the "Four Team Concept." The practice created four teams that each included a staff physician, a resident from each class year, a physician's assistant, and a representative from the nursing staff. Roles were redefined, with nurses as the point of contact for patient phone calls on their respective teams, as well as for managing refills and preventive services ordering. The health center and the residency program were also placed under a single CEO, Dr. Rob Freelove, to underscore the mutual interdependence. The project receives technical assistance from Leawood, Kansas-based TransforMED, a subsidiary of the AAFP.

Medical Home Summit Completes Successful 2nd Event

The Second Medical Home Summit wrapped up its second annual event on Tuesday, March 2 with more than 275 attendees on site, well over the 2009 attendance. A record number 60 people also attended the Sunday afternoon preconference Boot Camp. Conference co-chairs included John Iglehart, PCPCC leaders Edwina Rogers and Dr. Paul Grundy, Dr, Margaret Kirkegaard from Illinois Health Connect, Ann Torregrossa from the Governor's Office of Health Reform in Pennsylvania, and Dr. Lisa Letourneau from Quality Counts in Maine, who chaired the Boot Camp.

The conference was streamed live over the Internet, and the video archive of all presentations will be available for purchase by mid-month. *Medical Home News* was a special media sponsor of the Summit and offered a discounted subscription to all attendees.

Florida Medicaid Medical Home Task Force

The Florida Agency for Health Care Administration recently sent the report of its Medicaid Medical Home Task Force to the Governor and legislature. Authorized by state legislation in 2009, the ten-member task force comprised medical and health care professional associations, advocacy groups, medical schools, and Florida Medicaid health plans and providers.

Task force recommendations for a new state pilot program included:

- Using NCQA standards as the guide for the model
- Ensuring at least one rural model and one urban model with an academic medical center in the pilots
- An advisory board to suggest the best model for different kinds of Medicaid recipients
- Requiring pilots to include behavioral and mental health as well as 24/7 primary care
- A mix of different payment approaches, including case management fees and performance incentives

For the full report see www.ahca.myflorida.com.

INDUSTRY NEWS

PCPCC Stakeholders Meeting Set for March 30

The Washington, DC-based Patient-Centered Primary Care Collaborative (PCPCC) is set for its next major stakeholder meeting in Washington, DC on March 30 with the theme "Cultivate the PCMH."

continued

The day-long event at the Ronald Reagan Building at the International Trade Center will be preceded by a reception the previous evening, March 29, in the lobby of The Homer Building, the home of the PCPCC. David Blumenthal, MD, MPP, HHS National Coordinator for Health Information Technology is the keynote speaker, joining a group of medical home experts and practitioners from throughout the country. The registration link for the stakeholders meeting is listed on page 2.

A Selective List of National Medical Home Web Sites and Resources

The Patient Centered Primary Care Collaborative
www.pcpcc.net
A national, voluntary network of organizations and individuals supporting advocacy, research, & networking on medical homes

National Center for Medical Home Implementation - American Academy of Pediatrics
http://www.medicalhomeinfo.org/
A national resource specific to pediatric medical homes

CMS Medicare Medical Home and Advanced Primary Care Initiatives
http://www.cms.hhs.gov/demoprojectsevalrpts/md/list.asp
Select Medicare Medical Home Demonstration, Multi-payer Advanced Primary Care Initiative, or Federally Qualified Health Center Advanced Primary Care Practice Demonstration for updates

Technical Assistance Available to Participants Interested in the Medicare Medical Home Demonstration (MMHD)
www.medhomeinfo.org
Resources supported by a grant from the John A. Hartford Foundation to the Roger C. Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health and designed specifically for practices interested in the eventual Medicare Medical Home Demonstration

The Center For Medical Home Improvement (CMHI)
http://www.medicalhomeimprovement.org/
Sponsored by the Crocheted Mountain, a charitable organization. serving individuals with disabilities and their families, CMHI provides resources and consultation for medical home development and transformation.

Catching Up With …

John Iglehart, Founding Editor, *Health Affairs*, and National Correspondent, *New England Journal of Medicine*, Washington, DC. For 27 years, John Iglehart has held editorial leadership positions in the world of health policymaking -- as editor-in-chief of *Health Affairs,* which he founded, and as national correspondent of *The New England Journal of Medicine,* for which he still writes. A recognized expert on health policy and health politics, he sheds a little light on both, plus shares something intensely personal.

John Iglehart

- National Correspondent, *New England Journal of Medicine* (1981-Present)
- Founder and Editor, *Health Affairs* (1981-2007)
- Vice president, Kaiser Foundation Health Plan and Director of its Washington, D.C. office (1979-81)
- Various editorial positions, including Editor, *National Journal* (1969-1979)
- Elected to membership in the Institute of Medicine (IOM) of the National Academy of Sciences (1977) and member of the Governing Council (1985-1991)
- Elected member, National Academy of Social Insurance; Advisory Board member, National Institute For Health Care Management
- BA degree in journalism, University of Wisconsin-Milwaukee and journalist-in-residence, Harvard University

Medical Home News: *A good part of what was behind the surprising Massachusetts Senate vote seemed to be real discontent with the closed process being used to advance health care reform. Do you have a sense of* déjà vu *that we have a kind of "Magaziner" effect going on that could impede or derail the Obama plan the way the Clinton plan experienced?*

John Iglehart: I don't compare the Clinton effort to enact comprehensive health-care and insurance reform with the struggle that is being waged by the Obama administration. Current reform efforts are not an isolated activity but one of a panoply of issues that Obama faced when he took office. It should be viewed in the context of an unusual time in American history when a new administration had to rescue an economy that required trillions of public dollars, had to deal with unending wars in Afghanistan and Iraq and has had to cope with an unsettled public concerned about the vast expansion of federal power in a society that favors limited government. Finally, the Republican Party has changed dramatically since 1993. Its moderate wing has disappeared and it's now dominated by conservatives who are totally opposed to Democratic efforts at reform.

***Medical Home News*:** *We know who the big losers were with regard to the recent Supreme Court decision regarding corporate political campaign contributions -- it is we television viewers! But who was the bigger political winner -- Republicans via big business or Democrats via the labor unions?*

John Iglehart: On its face, one would have to assume that the Supreme Court decision would favor private corporations that have the resources to contribute generously to the candidates of their choice. But the decision also could spawn unintended consequences, such as an energized consumer sector that takes exception to the ruling, a call to arms by organized labor to increase its contributions and actions by Congress to deflect the impact of the decision. One reality we do know is that even before the impact of the decision is felt, private companies and organizations spent more than $544 million to lobby health-reform legislation in 2009, obliterating the 2008 total. Of six organizations that lobbied heavily on health-care reform—AARP, AMA, big Pharma, Blue Cross-Blue Shield, Chamber of Commerce, and Pfizer—all of them are ranked among the top 10 campaign contributors in 2009.

Medical Home News: *The health care reform debate thus far has been largely about health insurance, not health care delivery, reform. ACOs and the medical home have received pats on the head and some demonstration money, but fundamental restructuring of payment, delivery, and workforce issues seems to have been sidestepped. Why is that?*

John Iglehart: While the fee-for-service payment model is widely discredited as an approach that rewards quantity of services rather then their quality and fuels medical inflation, there is no alternative model that could readily replace it. If you recall Congress' enactment in 1983 of DRGs to slow hospital spending, it had been tested for many years through Medicare demonstrations. So Democratic reform proposals direct Medicare to develop pilot projects on ACOs, medical homes and other approaches; but the results are years away while Rome, in the form of soaring health-care expenditures, burns brightly.

***Medical Home News*:** *Is the patient-centered medical home in danger of being labeled the "new new thing" and overburdened with expectations that it can "save" the heath care system?*

John Iglehart: I do worry that policymakers may require that a medical home incorporate so many attributes that it will slow its evolution and the potential for scaling it up nationally—even as the urgency for reform accelerates. For example, a definition in several legislative proposals stipulates that medical homes must have an "integrated, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies." Beyond these requirements, many policymakers believe that if the medical home is going to be a "game changer," it will have to not only demonstrate a capacity to coordinate care and provide 24/7 service, but also slow the growth of expenditures.

Medical Home News: *Finally, tell us something about yourself that few people would know.*

John Iglehart: In my long career as a journalist and commentator I have worked in every area of print media, but no television, blog or Twitter. I covered high school sports for the *Milwaukee Sentinel* in college, was a reporter-photographer for the *Dubuque Telegraph-Herald* after graduation, spent six years with The Associated Press, and held every editorial position at the *National Journal* over 10 years before founding the policy journal *Health Affairs* and serving as its editor-in-chief for 26 years. I have also served as a national correspondent for *The New England Journal of Medicine* since 1981, a publication for which I continue to write. I have had a wonderful career but have also lived with a family tragedy—we lost our only son to leukemia in 1997, after he battled that dread disease for 5 years.