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Medical Home NEWS

Evaluation and the Patient-Centered Medical Home

By Meredith Rosenthal, PhD, Melinda K. Abrams, MS, and Asaf Bitton, MD, MPH

With the 2010 Patient Protection and Affordable Care Act extending the promise of health insurance coverage to millions, now more than ever Americans need delivery system reform that can assure meaningful access at affordable cost to the nation. Both federal and state policy makers have taken steps to test and promote a series of policy changes that will reward providers for assuming accountability for patient outcomes and the cost of care. While these changes in accountability are intended to stretch along the continuum of care, a reinforced primary care stratum is a central component to most proposals. Moreover, the patient centered medical home (PCMH) has been a key organizing framework within which primary care reform is being implemented in support of broader system goals of improved quality and affordability of care.

An Opportunity to Refine the PCMH

Individual components of the PCMH have been shown to be associated with higher quality and patient experience[1], but published evaluations of the model as currently formulated have only just begun to emerge in the literature. Findings published during the past year have underscored both the potential for PCMH initiatives to impact health care spending, quality of care, patient and physician experiences, and the obstacles to change that are likely to exist in the vast majority of primary care practices.[2]

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Coastal Medical, Inc: Transformation to a Patient Centered Care Model

By Anne VanHaaren, PharmD, CDOE

There are currently numerous pilot projects underway across the U.S which are successfully demonstrating the transformation of practices to a patient centered medical home (PCMH) model. Many of these projects have demonstrated both an increase in the quality of care being provided as well a reduction in the total cost of care. Questions remain as to how this model might best be extended beyond demonstration projects, and whether or not the improved quality and cost savings achieved in demonstration projects will be realized with spread of the model across a broader community of providers.

Coastal Medical is one of the largest private providers of primary health care in Rhode Island, serving greater than ten percent of the total Rhode Island population. The organization is a physician owned professional corporation that encompasses 17 practice sites across the state. Our 67 physicians, 24 mid-level providers, and 150 care team members provide predominantly primary care in internal medicine and pediatrics, plus a smaller volume of adult subspecialty care in cardiology, pulmonary medicine, and infectious disease. We also provide ancillary services through our imaging center and mostly in-office laboratory sites.

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Medical Home News
1101 Standiford Avenue, Suite C-3
Modesto, CA 95350
Phone: 209.577.4888
Fax: 209.577.3557
info@medicalhomenews.com
www.MedicalHomeNews.com

Editor's Corner

Raymond Carter, Editor, *Medical Home News*

We are going to take a break from the Op Ed schedule this month because I have the pleasure of introducing another new member of the *Medical Home News* Advisory Board.

Deborah Peikes, PhD, MPA is a Senior Researcher at Mathematica Policy Research in Princeton, NJ. She is also a Visiting Lecturer at her alma mater, the Woodrow Wilson School at Princeton University. She brings a critical research and evaluation perspective to the advisory board. Her brief bio is below.

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

Debbie Peikes, a senior researcher at Mathematica Policy Research**,** is an expert on designing and evaluating medical home and disease management programs. She directed a $1.25 million AHRQ project on the medical home and consults with UnitedHealth Group on designing and evaluating its PCMH initiatives. She also directed a project advising CMS on the design of the Medicare Medical Home Demonstration.

Dr. Peikes has written about measuring the medical home, patient attribution, patient engagement, exchanging information among providers, and payment options, and has presented widely on PCMH topics. She is also the project director or principal investigator on a number of projects to determine when and for whom care coordination—a central component of the medical home—improves outcomes for people with chronic illnesses. Her co-authored article in *JAMA* on this subject was honored with two awards for the best paper of the year. A speaker at the Second National Medical Home Summit in March 2010, she also subsequently conducted a national audioconference in May on why some medical home evaluations succeed and some fail.

Dr. Peikes received both her Masters of Public Affairs and her PhD from the Woodrow Wilson School at Princeton University, where she currently teaches a graduate class on program evaluation.

The National Medical Home Summit
The Leading Forum on the Development and Implementation of the Patient Centered Medical Home
A Hybrid Conference, Internet Event and Training Tool

THIRD NATIONAL MEDICAL HOME SUMMIT

March 14-16, 2011 – Philadelphia, PA

Call for Presentation Proposals

The Third National Medical Home Summit has issued its call for presentation proposals. The Summit is especially interested in proposals from current medical home models with lessons learned and outcomes to report. Companies assisting physician practices in the transformation process are encouraged to submit a proposal with a client. Proposals are being accepted until October 15 via the following page on the conference web site:
http://www.ehcca.com/proposals/presentations.php?id_form=31

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Patient Experience: A Vital Cog in Medical Home Success

By Anthony Cirillo, FACHE, ABC

As accountable care organizations become more defined and reimbursement worked out, it is clear that the marketplace will be moving into coordinated care that in theory will result in better quality outcomes and lower costs.

But will it result in a better patient experience?

Consider this. More patients will be flooding into the system (and the doctor's office). Baby boomer physicians are on the cusp of retirement. Fewer people are choosing medicine, let alone primary care medicine, as a career. That said, no amount of coordination, even when aided by all the promise of IT, will make the patient experience better. That experience starts at ground zero, the medical practice that is morphing into the medical home. But some are jumping way ahead in what they think needs to happen.

First, the foundation of any medical home must be built upon sound practice management. Physicians are ill-equipped business people. And hospitals sometimes are no better prepared to run the practices they are gobbling up. Eliminating the operational inefficiencies in a practice translates into increased revenue and provides the basis for the other components of the medical home to lie upon.

Next, consider that patients do not judge their health care by the quality of the clinical care. They judge it by the total experience. So if any part of that experience breaks down, that could be the one factor that causes you to lose customer loyalty and have negative word of mouth spread about the organization.

Patient experience is different than patient satisfaction. Yes, CMS is using HCAHPS to measure satisfaction, but the questions are meaningless because they tell nothing about the actual experience. Yet this metric is being used in some rudimentary way to affect reimbursement, and as the reporting measures become more robust around experiences, this metric will probably take on as much significance as other clinical indicators.

So practices must have an end goal of providing exceptional patient experiences. The problem has been that industry addresses experience management with a "program of the day" mentality. In other words, they pile on some customer experience initiative on top of someone's other responsibilities. They bring in mystery shoppers. They map the experience. And they miss the point.

Changing an organization's culture to one that focuses on customer experience takes full-time leadership. Experience management must be part of the culture where each employee is authentically empowered to change experiences through self-motivated action. That culture can be fast-tracked if you consider hiring a leader in the role of Patient Experience Officer.

THE PATIENT EXPERIENCE OFFICER

On the hot job list at *Fast Company* is a position that might not be familiar to most: experience designer. Most experience designers can be found in the retail industry, creating the essence and aura of a store. Their work goes far beyond just the look of a place. They make consumer experiences in which shoppers can immerse themselves. The American Girl doll stores in New York, Los Angeles, and Chicago are obvious examples.

We first proposed this idea in 2007, calling it The Chief Experience Officer. And the Cleveland Clinic used that a basis to start their office of patient experience and employ the nation's first hospital experience officer. Their emphasis was three-fold: employee experience, patient experience, and the spiritual/emotional experience.

As health reform plays out, the nature of health care will emphasize hospital care less and care that keeps you out of the hospital more! So consider the role of experience officer for a medical practice. Every aspect of the practice needs to be graded and awarded based on delivering a great customer experience. Adding a patient experience officer unifies efforts, ties them to external marketing, and fully integrates experience management with clinical coordination. Even medical practices work in silos!

The Culture Must Support It. If the chief executive is intent on instituting changes and will hold all executives accountable, then an experience officer can help as a change agent. But if the plan is to make the experience officer solely responsible, then reconsider having this position. An experience officer looks at the customer from the enterprise perspective and cannot influence change without participation and commitment from leaders. Their further commitment to empowering employees is inherent in the buy-in.

Obtain Buy-in. If you have been actively fostering a culture of great experience, then it will be a smooth transition to look at bringing on an experience officer as a next step in the journey. As with any new position, it will be viewed as an opportunity by some -- but a threat to others.

That is when organizations need to look at the big picture. The education and expectations of the consumer are increasing. Although they consider quality and satisfaction data when making choices, they also look at experiences. They talk to others. And they surf. Practice experiences, like Amazon book reviews, are being documented in narratives on the Internet. This is the brave new world of selection. All else being equal, it's the experience.

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Patient Experience*…continued*

Define the Position and Competencies. Here a few things to keep in mind:

- This person must be able to work across the enterprise. That means being able to build relationships, from the CEO to the maintenance man. Each person in the organization will have different ways of understanding the concept.
- This person must be able to synthesize data across the organization about customers and connect metrics to customer experiences.
- This person must be able to leave his/her ego at the door and make others own and take credit for the experience that he/she will help guide.

Start Small. A commitment to this position means that everything cannot be done in six months, a year, or even two years. Working behind the scenes as an experience officer, you need to understand -- across the entire enterprise -- the key customer service trends and issues. Define specific deliverables for the first three and six months. Be clear. While you may start in one area of operation, what you do there is an influencer for what is to come. Never lose sight that across the practice one experience needs to be defined. When delivered consistently throughout the organization, it will become part of a brand that people will talk about.

And it does become part of the culture. NASA knows a thing or two about this. When visiting dignitaries would tour NASA in the 1960s, they stopped and asked a janitor what his job was. He replied "to put a man on the moon." NASA understood the end goal, the ultimate experience, and had everyone talking from the same page. Disparate jobs, guided by an experience officer, develop one harmonious chorus over time. Consider how your employees answer the question: What's your job?

EXPERIENCE MANAGEMENT AND GROWTH

Despite a dip, health care building has not really lagged, and as more hospitals gobble up and integrate practices, and as practices merge into mega-practices, it is only natural that they will migrate into newer facilities. Having someone on board to guide and unite what architects do will ensure building projects are not just aesthetically appealing, but also yell "experience" from the moment you walk in the door.

BRAND EXTENSIONS

Services are also splintering off in new directions, with practices operating urgent care centers, retail clinics, and moving into concierge medicine. Someone must unite these efforts and develop an experience that is also tied to the brand.

MEDICAL TOURISM

Medical tourism is a real phenomenon, and it's not just about going overseas. Having done some medical tourism consulting overseas, I tend to see what lessons we can learn from this on a local basis. One of the things that clearly strikes me is the idea that healthcare is not necessarily local. For example, Lowe's home improvement recently announced that all of the cardiac surgery for employees would go to the Cleveland Clinic. It made me pause.

continued

Patient Experience*…continued*

Living just miles from Lowe's headquarters (near Charlotte, NC) and surrounded by very good major medical centers, it had to send a shock wave locally to these hospitals. Lowe's realizes that while the initial cost may be higher (or not), they are paying for the quality that the Clinic has and betting that overall costs (fueled typically by possible readmissions, etc.) will be lower because their employees will be taken care of right the first time.

So what about physician practices? Will people travel beyond their locale for care? I followed my physician when he moved from five minutes away to forty. Why? You guessed it. The experience. The experience of sound outcomes. The experience of taking the necessary time with me. The experience of care coordination and timely feedback and responsiveness. Does my physician's practice have an experience officer? No, but they happen to be part of a health system that is laser-focused on experience management.

IMPACT ON MARKETING

All of this certainly changes the complexion of marketing. And it calls more for figuring out how to leverage word of mouth and patient stories in the offline and online world. And no doubt in the future these decisions to use distant providers will not only be fueled by quality metrics but also on metrics surrounding the health care experience.

So if you are really exceptional, people will find you. Exceptional will be defined by the experiences you offer. People will travel for exceptional. And people will answer yes to the ultimate question – will you recommend us to others? Exceptional can be fast-tracked with a Patient Experience Officer.

Anthony Cirillo, FACHE, ABC, is president of Fast Forward Consulting, which specializes in patient- and person-centered care and strategic marketing for healthcare facilities. He can be reached at cirillo@4wardfast.com.

Evaluation and the Patient-Centered *…continued*

While recent reports offer some tantalizing results and important cautionary lessons about the conditions necessary to implement the practice changes associated with becoming a PCMH, the extant literature raises as many questions as it answers. How will small practices transform to become medical homes? Will it be feasible to support PCMHs in multi-payer contexts? What aspects of the PCMH are linked to improved outcomes and for which patient populations? What is the best way to define a medical home and measure transformation toward this goal? Fortunately, over the last several years a large number of PCMH pilots have been launched and more are in the development phase. To the extent that they are accompanied by well-designed evaluations, these pilots will help to build an empirical basis for the PCMH concept and begin to address the myriad questions surrounding implementation and impact of the PCMH on desired outcomes. Moreover, standardization of methods and measures among these evaluations will allow for cross-study comparison or pooling of results and greatly increase the usefulness of findings for policy makers and other critical stakeholders such as patients, providers, and payers.

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Evaluation and the Patient-Centered Medical Home...*continued*

A Snapshot of Selected Ongoing PCMH Evaluations

Many of the roughly 30 regional and national PCMH pilots underway are linked to ongoing or planned evaluations (Bitton, et al., 2010). In the section that follows, we describe a selected sample of pilots and their associated evaluations to convey both the diversity of pilots and the potential for cross-pilot learning that could be facilitated through purposeful alignment of their respective evaluations.

	Emblem Health New York	Chronic Care Sustainability Initiative RI	Safety-net Medical Home Initiative	New Orleans PCASG	Colorado PCMH Pilot	Cincinnati AF4Q PCMH Pilot	Mid-Hudson Valley	Primary Care Global Fee Model	Penn. Chronic Care Initiative
Geography	NY	RI	CO, ID, MA, OR, PA	LA	CO	OH	NY	NY, MA	PA
Number of…									
Practices	33	5	65	93	15	11	15 (70 sites)	5	126
Physicians	87	28	492	336	45	41	~1,000 (282 PCPs)	37	~540
Patients	15,024	25,000	554,570	292,000	20,000	30,000	~600,000	62,500	~800,000
Payers	1	4	0	1	6	3	6	1/1	12
Medicaid included	No	Yes	No	No	Yes	No	No*	No	Yes
Safety-net clinics included	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Payment model	FFS, and P4P.	PMPM care management fee and FFS.	Not applicable	Base payment dependent on number of eligible providers, bi-annual grant award for improved access and P4P.	PMPM care management fee, FFS, and P4P.	PMPM care management fee, FFS, and P4P.	Bonus for medical home implementation and separate annual P4P bonus.	Risk-adjusted, comprehensive annual primary care fee.	Two PMPM care management fee models, a shared-savings model, and a one-time grant model
Key Features	Bonus incorporates performance on patient experience surveys. Randomized control trial. External consultant provides care coordination and practice redesign.	Participating payers cover more than two-thirds of state enrollees.	Largest national safety-net initiative. The Fund's demonstration project.	Part of the health care recovery effort in the wake of Hurricane Katrina. Includes only safety-net clinics.	Multi-state project with OH AF4Q PCMH pilot.	Multi-state project with CO-PCHM pilot.	Assesses incremental effects of EHRs and medical home.	High-performing practices participating. Unique payment model.	Most extensive multi-payer medical home pilot in the nation with four distinct payment models.

*Medicaid is not a participating payer per se, but Medicaid managed care patients are included

Table 1 Abbreviations Key

AF4Q:	Aligning Forces for Quality	**PCMH:**	Patient-centered medical home
EHR:	Electronic health record	**PCP:**	Primary care physician
FFS:	Fee-for-service	**PMPM:**	Per-member per-month
PCASG:	Primary Care Access and Stabilization Grant	**P4P:**	Pay for performance

Table 1 identifies nine PCMH pilots whose evaluations are being supported by the Commonwealth Fund and describes some of their key features (more detailed information on these and other pilots is available in Bitton, et al., 2010). These pilots are a convenience sample (convenient because we have access to detailed information about their evaluations) but, not coincidentally, they are also representative of the larger cohort of PCMH pilots. The nine pilots featured here all involve multiple physician practice sites and some coordinated efforts to support practices through payment reform in their efforts to adopt structures, processes, and cultural changes necessary to approach the ideal of the PCMH.

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Evaluation and the Patient-Centered Medical Home*…continued*

On most other dimensions there is considerable heterogeneity. For example, most involve multiple payers (insurers and in several cases Medicaid), but some have no direct payer involvement or only a single payer. Likewise there is considerable variation in the use of incentives for participating practices – some involve only in-kind transfers (e.g., technical assistance), most offer per member per month care management fees, and a few involve targeted incentives through pay for performance or shared savings.

Table 2. Evaluation Descriptions

	Emblem Health New York	Chronic Care Sustainability Initiative RI	Safety-net Medical Home Initiative	New Orleans PCASG	Colorado PCMH Pilot	Cincinnati AF4Q PCMH Pilot	Mid-Hudson Valley	Primary Care Global Fee Model	Pennsylvania Chronic Care Initiative
Research design	Randomized controlled trial	Pre-/post-analysis with controls	Pre-/post-analysis with and without controls	Pre-/post-analysis; no controls	Pre-/post-analysis with controls	Pre-/post-analysis with controls	Pre-/post-analysis with controls	Pre-/post-analysis with controls	Pre-/post-analysis with controls
Time frame of pilot to be evaluated	01/07-31/10	10/08-10/10*	02/08-10/13	08/08-12/10	05/09-05/11*	09/09-09/11	11/09-11/11	01/08-12/10*	05/08-09/12
Domains examined:									
Clinical quality	x	x	x		x	x	x	x	x
Health care costs and utilization	x	x	x	x **	x	x	x	x	
Patient experience	x	x	x	x	x	x	x	x	x
Physician/staff experience	X	x	x	x	x	x	x	x	x
Practice cost			x					x	
Process/qualitative	x	x	x		x	x		x	
Structural (NCQA or other metrics)	x	x	x	x	x	x	x	x	x
Impact on disparities			x	x					

* These pilots are planning to run an additional year; it is possible that the evaluations will be extended to capture an additional year of information as well.
**Examining the number of primary care visits only.

Table 2 describes the basic structure and scope of the evaluations for each of the nine pilots, including the research design, time frame, and major domains of measurement. The majority of evaluations are seeking to identify impact based on pre-/post-intervention changes alongside a contemporaneous comparison group, although one evaluation (Emblem) is using a randomized design. Nearly all the evaluations will examine impact on clinical quality of care, patient experience, and physician/staff experience as well as performance on the NCQA Physician Practice Connections®-Patient Centered Medical Home criteria for accreditation. A couple of the evaluations have unique components such as a focus on racial and ethnic disparities or practice costs associated with being a medical home.

Evaluators Collaborative

With so many different approaches to implementing the PCMH in varied delivery system and population contexts, there will no doubt be a wide range of experiences and results. Such diversity creates both challenges (for example, what do we make of conflicting results or measurement using different tools?) and opportunities for additional learning by comparing findings along specific dimensions of pilot structure or context. In large part to foster opportunities for meta-analysis of pilot outcomes through alignment of evaluation metrics and methods, the Commonwealth Fund organized a collaborative of independent PCMH evaluators. Since June 2009, the PCMH Evaluators Collaborative has convened quarterly to strengthen and coordinate PCMH evaluations with the objective of supporting improvements in policy and practice. Members of the PCMH Evaluators Collaborative, which include but are not limited to Commonwealth Fund sponsored investigators, are actively engaged in assessing PCMH demonstrations.

The Collaborative has undertaken to:

1. gather and share data collection instruments;
2. seek consensus on a core set of outcome measures in 4 areas (clinical quality, physician/staff experience, cost and utilization, process/implementation); and
3. foster an ongoing and supportive exchange where evaluators share ideas that improve the design and interpretation of evaluations.

To date, groups of Collaborative members have disseminated recommendations for measurement in two areas. First, a group proposed a set of principles and core measures to capture the cost and utilization effects of the patient-centered medical home (Rosenthal, et al., 2010.) A second group has developed guidance for the scope and depth of evaluation required to shed light on the complex interventions and systems that underlie PCMH pilot projects (Crabtree et al., In Press).

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Evaluation and the Patient-Centered Medical Home…*continued*

The Collaborative will continue to develop resources for evaluators and PCMH stakeholders, including but not limited to recommendations regarding measures in the areas of clinical quality and physician/staff experience, in order to promote learning and refinement of the PCMH. Additional, related work by NCQA and the CAHPS Consortium will present recommendations in the domain of patient experience in January 2011.

A Work in Progress

While the PCMH concept has become an important focal point for policy initiatives to address fragmentation and waste in the delivery system, achieving its vision of coordinated, patient-centered care will require that we learn more about the ways in which practices need to change and how such changes can be brought about. Well-designed, richly detailed, and coordinated evaluations are essential to this process and the future prospects for the PCMH.

Meredith B. Rosenthal, PhD is Associate Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health in Boston, MA. She may be reached at mrosenth@hsph.harvard.edu. Melinda Abrams, MS has just been promoted to Vice President and Director of the Patient-Centered Coordinated Care Program for The Commonwealth Fund in New York City. She may be reached at mka@cmwf.org. Asaf Bitton, MD, MPH is Instructor in Medicine, Division of General Medicine, Brigham and Women's Hospital, Boston, MA. He may be reached at abitton@partners.org.

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3 Several of the evaluations are co-funded. The Colorado Trust is supporting the evaluation of the Colorado PCMH Pilot; The Jewish Healthcare Foundation is supporting the evaluation of Pennsylvania Chronic Care Initiative; Emblem is contributing resources to data collection for the evaluation of their pilot.

Coastal Medical, Inc.…*continued*

Coastal Medical has recently developed a new strategic plan, and the cornerstone of that plan is the transformation of each of the practice sites using a patient centered, team based model of care. Our vision is to create Patient Centered Medical Homes in each one of our primary care practices. As part of that plan, we are using the National Committee for Quality Assurance (NCQA) standards for the Patient Centered Medical Home to measure our achievement of this goal. We have received NCQA Level 1 recognition in 16 sites. Our goal is to resubmit by November of this year to achieve Level 3 recognition for those practices.

The Chronic Care Sustainability Initiative

A primary stimulus to our practice transformation efforts has been Coastal's participation in the Chronic Care Sustainability Initiative (CSI) here in Rhode Island.

CSI is a multi payer, state-wide patient centered medical home pilot project which pays the practices a PM/PM fee, provides training support, and covers the salary of a nurse care manager for each office. The project has recently expanded to include a total of 12 practices throughout the state, two of which are Coastal Medical sites. It is run by a large steering committee composed of representation from all of the stakeholders in the state. There are seats for the Office of Health Insurance Commissioner, the health departments, physician practices, payers and purchasers of insurance, and regional quality organizations. Reporting on clinical outcome measures is done quarterly, and process improvement is occurring in each of the offices based on the results of that reporting. Best practices have been shared regarding both how care is provided and how data is collected. After close to two years of participation, our data has now become an accurate reflection of the care being provided to these patients, and we are seeing a positive change. Based on the last report, the project has demonstrated a greater than 50% improvement in goal attainment for diabetics reflected by A1c and LDL measurement. There has been an 80% increase in the number of smokers who are counseled to quit.

The incorporation of the nurse care manager (NCM) into our CSI practice sites has greatly enhanced the coordination of care for the patients at those sites. Having the NCMs engage patients and families in the process of care has been particularly beneficial at points of transition between healthcare settings and at times of crucial decision making in a

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Coastal Medical, Inc.*…continued*

patient's journey through the system. The nurse care managers receive weekly data from the plans identifying patients who have had an emergency department (ED) visit and have been hospitalized. The NCM uses that information to follow up with the patients and schedule them to come to the office. The data is still being analyzed, but we expect that there will be a decrease in ED use as well as a decrease in the frequency and cost of hospitalizations. Our involvement in CSA has informed our strategic planning, and we have begun the process of expanding patient centered care in all our practices.

The Key Elements: Leadership, Education, and Technology

Our experience to date suggests that the key elements required for achieving success in implementing patient centered care throughout these practices will lie in three areas: leadership, education, and technology. Coastal Medical has established a significant corporate infrastructure which supports the practices. We are a physician owned organization, and physician leadership is prevalent in all aspects of decision making. Coastal also funds a robust continuing medical education program. This program is proving to be a key element in the process of educating our staff, our providers, and other members of the medical community. Coastal has remained on the cutting edge of health information technology. Our implementation of technology is supported by a small but very talented Information Technology department currently composed of three full time individuals.

LEADERSHIP: Physician leadership is a key element for practice transformation. From organizational strategic planning right down to team development in each office, physicians act as leaders. Important clinical and financial decisions at the group level are made by physician-led committees. The Coastal Clinical Process Team has representatives from each level of patient care including physicians, nurse practitioners, medical assistants, and office managers; as well as the clinical data analyst, the IT director, and other members of the management team. This team designs and approves the process changes necessary to move each office toward becoming a patient centered medical home. Our physicians believe in the transformation of their practices to a more patient centered model of care. Each office has a physician leader who acts in conjunction with the office team to carry out the plans and decisions of the committees.

"Physician leadership is a key element for practice transformation. From organizational strategic planning right down to team development in each office, physicians act as leaders."

EDUCATION: Coastal's continuing medical education program has provided substantive support to the education of our group. Most recently, we completed a three-part series on Practice Transformation and Redesign that attracted national speakers to inform our efforts. This series included speakers on general topics helping our staffs to understand the concepts and principles of the patient centered medical home. Each educational session had a practice transformation component featuring one or two speakers, followed by a clinical session dedicated to a specific topic relevant to the disease management initiatives we have undertaken in support of our NCQA applications.

In addition, we have employed a full time in-house trainer for the electronic medical record. His job is to provide training on new features of the record as they are rolled out by the software vendor. He also supports training for new providers and staff and meets with anyone who would like to become a better EMR user through improved efficiency and accuracy of documentation. The ongoing education of our providers and staff is a key element in our effort to transform each practice site to a full-fledged Patient Centered Medical Home.

INFORMATION TECHNOLOGY (IT): In 2006, Coastal Medical implemented a fully integrated electronic health record. The record was successfully implemented in all of our practices and is used to document all aspects of patient care for 100% of our patients. The documentation of clinical care and the ability to extract specific clinical information from the electronic health record allows us to collect data on our patients and use it to effect positive change in the management of our patient populations. Our IT staff support more than 400 users of the electronic health record using a single server model. We service our users with our own online help desk. Using state of the art technology, our IT team maintains all of our hardware needs, supporting equipment in the clinical offices as well as the corporate network. With the support of this staff, Coastal is able to implement the latest upgrades to our electronic health record software. The new features available improve our ability to report out on the quality of care provided to our patients. We are in the planning stages of rolling out a patient portal to allow patients connectivity to their health information in our offices. We are also working to enhance interoperability and to support the development of a statewide Health Information Exchange in order to improve access to key clinical information about our patients, particularly at transitions of care.

Conclusion

The road to practice transformation is a long one. Expanding our experience with the Patient-Centered Medical Home model is an ongoing process. We believe this change will result in improved patient experiences, improved clinical outcomes, and reduced costs. Our deep involvement in the work of the Chronic Care Sustainability Initiative over several years has profoundly informed and influenced our organization's commitment to practice transformation. Our recent experience at Coastal Medical provides an example of a process whereby the collaborative learning from a pilot project like CSI can be effectively extended to a larger group of providers.

Anne VanHaaren, PharmD, CDOE is Director, Clinical Quality Management at Coastal Medical, Inc in Providence, RI. She can be reached at avanhaaren@coastaldocs.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 you see as ideal integration between primary care and behavioral health in the medical home? What barriers are likely to be encountered, and how are they best overcome?"

"In a small practice, (under four PCPs), I think the optimal use of the PCMH additional payments would be to add one staff member trained to do depression care management (one of the three chronic illnesses for which the practice has a protocol), care coordination, and behavioral interventions like brief CBT interventions, patient education, and motivational interviewing. Because of the high instance of behavioral health needs intertwined with the medical needs in most chronic illnesses, care coordinators will need behavioral health training, whether or not their credential is in a mental health discipline. In practices with four or more PCPs, a proportional number of behavioral health clinicians should be part of the practice in addition to (or also filling the role of) care managers. The number depends on the number of PCPs and the behavioral acuity of the population serviced. There is strong evidence for the effectiveness of behaviorally trained care managers supervised by psychologists or psychiatrists in caring for very complex patients in the PCMH. In most practices, the onsite Behavioral Health Clinician will be a psychologist trained in primary care behavioral health with a psychiatrist consulting to PCPs from another location. Psychologists, social workers, and nurses in these roles will need special training in working in primary care if they are to succeed in the PCMH. This is the kind of training we offer at the University of Massachusetts Medical School Certificate Program in Primary Care Behavioral Health."

Alexander Blount, EdD
Professor of Family Medicine and Psychiatry
University of Massachusetts Medical School
Worcester, MA

"The integration of mental health care into the Patient Centered Medical Home will be crucial to the success of the medical home. Many people seen in primary care could benefit from the availability of mental health care as part of the services of the medical home, including people with common mental health conditions (e.g. anxiety, depression, substance use disorders), people with chronic illnesses (e.g. CVD, diabetes, COPD), people whose health will be improved by behavior changes such as smoking cessation and increased exercise, and people who are dealing with the emotional aspects of illnesses. Barriers to successful integration include the fact that integration requires primary care and mental health clinicians to learn new ways to work together, and that the current fee for service payment system does not support some of the time needed for communication and collaboration that are necessary for integration to be most effective.."

Neil Korsen, MD
Medical Director for Primary Care Mental Health Program
MaineHealth
Portland, ME

"Mental health is essential to health. The Integration of health and mental health services is critical and is likely to occur in two settings. The first is a traditional primary care based medical home, providing screening, treatment, and follow up to the many individuals who have mental illnesses and are seen in primary care settings. We know that importing mental health expertise into primary care settings increases diagnosis and treatment outcomes while reducing overall healthcare costs. The capacity to identify and treat basic mental illnesses should be an essential component of all medical homes.

The second area involves the sub population of individuals with serious mental illnesses who are seen in community mental health centers. Much less is known about optimal healthcare and successful health promotion for this group. With an average life expectancy as much as 25 years shorter than other Americans, persons with serious mental illnesses represent the most health disparate group in the US. Importing a medical home into a community mental health center that focuses on preventive care, health literacy, and basic health behavior for this very special group of people can literally be a lifesaver. We are working on just such a project in our community mental health clinic and have seen promising results.

A primary barrier to sustainability of integrated care in each of these settings includes the lack of care coordination financing for the integrated services. A medical home financing structure that includes care coordination and illness management strategies is the best hope for improving the mental health of many Americans seen in primary care settings, and for improving the basic health of Americans with serious mental illnesses."

Anita Everett, MD, DFAPA
Section Director
Community and General Psychiatry
Johns Hopkins Bayview Medical Center
Baltimore, MD

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*T*hought Leader's *C*orner ...*continued*

"Primary care physicians have been the behavioral health practitioners for most patients for decades. With inadequate training, a low level of interest, and limited time, we have struggled to provide adequate care. By integrating behavioral health specialists in the primary care setting, many patients will be able to get this kind of care for the first time and others will receive improved care at last. The ideal integration first requires PCPs to take an active role in the selection of the behavioralist. This is like adding a new partner to the practice. It is imperative that there be a good fit for all concerned. All providers must feel comfortable since the working relationships become very close. Having a vested interest in the selection process will go a long way to assure an effective working relationship in the future. The biggest barrier to success is a lack of clear understanding of what is expected of the behavioralist. Most practitioners can be very flexible, but without well-defined practice expectations, there are bound to be great disappointments. In our office we plan to include the behavioralist in all of our monthly evening provider meetings. This is at least one way to keep communication going in both directions. It is important to fully integrate the behavioral therapist as a full member of the team -- with all the stresses and strains implied by that full membership."

Allan Currie, MD
Chief, Medical Service
Eastern Maine Medical Center and Husson Internal Medicine
Bangor, ME

"To be patient-centered, integrated medical and behavioral health care should occur where patients receive the majority of their care. For most patients with co-occurring medical and behavioral health problems, this will be in a primary care setting as long as primary care providers have the tools to recognize and treat these problems, plus the training to use these tools properly. However, patients with severe mental or substance use problems are probably best served when they receive preventive, primary, and specialized physical health care in behavioral health care settings. There are many challenges to integrated care, including a financing system that limits reimbursement for behavioral health treatment in primary care settings, competing demands for provider time and attention, inadequate coordination and communication among providers, and the conventional wisdom held by many that behavioral health problems are fundamentally different from other medical problems. If these challenges are not enough, current quality, delivery system, and payment reforms will further stretch already overburdened practices struggling to maintain patient care. A coordinated approach to these multiple reforms is needed."

Thomas Croghan, MD
Senior Fellow, Mathematica Policy Research
Professor of Medicine and Psychiatry, Georgetown University School of Medicine
Primary Care Physician, Whitman Walker Clinic
Washington DC.

"Ideal integration between primary care and behavioral health requires 'collaborative care,' fully integrating the behavioral health provider into the primary care team. All visit and contact records and treatment plans are shared freely among all care team members to ensure patient engagement, coordinated care, and better outcomes in both behavioral health and medical co-morbidities. The latter are highly affected by unrecognized and/or uncontrolled behavior health conditions. True team-based care, by treating the "whole person," helps reduce the stigma surrounding behavioral health illness and the lack of recognition of its connection with medical conditions. The barriers are mostly cultural, as we still have a provider-centric culture, structure, and approach to care fostered all the way back to medical training that is not team-based or very collaborative. We clearly need both technical fixes and adaptive approaches to overcome these barriers long-term. To start, redefine roles, institute team-based workflows that coordinate the patient's care across care delivery systems, and normalize frequent team huddles and more co-management of a shared care plan so relationships and new behaviors are formed. This team-based approach can influence the organization to create the critical mass and processes to make the needed cultural changes."

Nancy Jaeckels
Vice President, Member Relations and Strategic Initiatives
Institute for Clinical Systems Improvement
Bloomington, MN

"In your question you need to include subspecialty care. Many of us in pediatric nephrology end up functioning like a medical home because our patients, who have complex medical regimes, require more care coordination than is available in the primary care clinics. One of the most important barriers is the lack of clear communication between health providers and other ancillary services (including the patients' schools). The use of a patient portal for an electronic health record may be one of the answers to this problem."

Maria E. Ferris, MD, MPH, PhD
Associate Professor of Pediatrics and Medicine
University of North Carolina School of Medicine
Chapel Hill, NC

Thought Leader's Corner …continued

"Recent syntheses of the literature, including AHRQ's Evidence-based Practice Report, have shown there are a number of proven and effective models of integration, as well as possible barriers. Among the barriers identified, the most common are related to financing and/or reimbursement for care; organizational issues related to change, burden, and sustainability; differences in cross-disciplinary cultures; and measurement. A number of initiatives are underway across the U.S. to address these areas with innovative payment models and structures, projects to develop effective team care, and a novel attempt to test new integration programs being developed using a 'bottom-up' approach to program design."

Charlotte A. Mullican, MPH
Senior Advisor for Mental Health Research, Center for Primary Care, Prevention, and Clinical Partnerships
Agency for Healthcare Research and Quality
Rockville, MD

"Ideal integration to me is co-located, interdisciplinary, team based care. Barriers are lack of sufficient interprofessional education and training of the health professions, plus reimbursement systems that do not recognize 'curbside consultations' or prohibit same day billing. A major barrier is the lack of understanding by other professions and policymakers of psychology as a broad-based health profession, not only a mental health profession. Behavior and health are inextricably intertwined across all health issues/problems."

Cynthia D. Belar, PhD, ABPP
Executive Director, Education Directorate
American Psychological Association
Washington, DC

INDUSTRY NEWS

HRSA Awards $2.6M to Integrate Mental Health

HHS's Health Resources and Services Administration (HRSA) recently awarded $2.6 million to 19 institutions to expand mental and behavioral health care services for vulnerable populations. The awards are part of the Graduate Psychology Education Program Workforce Training to Improve Access to Mental Health Services.

Special MCRR Issue on the Medical Home

The August 2010 issue of *Medical Care Research and Review* is devoted entirely to the PCMH -- definitions, payment, medical home effects on emergency department use, employer perspectives, and the ability of the medical home to reduce costs. The table of contents is viewable at http://mcr.sagepub.com/content/current.

New APA Statement on Medical Home

The Academic Pediatric Association (APA) has recently released a new policy statement addressing the similarities and differences between the pediatric and adult medical home models that should be noted in policy and research. See http://www.academicpedsjnl.net/current.

AHRQ Focuses on Integrated Primary Care

As if a scheduled companion piece to the Thought Leader question for this month, the August 18 issue of the *AHRQ Innovations Exchange* focuses on the topic of "Integrated Primary Care" -- the integration of behavioral health services (mental health, substance abuse, and health behavior change strategies) with primary care services. The featured Innovations describe three programs that developed integrated primary care services to address the needs of vulnerable patient populations. The featured Quality Tools describe learning modules and toolkits on how to develop integrated primary care services.

Humana, athenahealth Reward PCPs

Last month Humana announced a partnership with athenahealth that would connect Humana's Primary Care Rewards Program with athenahealth's electronic health record service. Under the new joint Medical Home EHR Rewards Program, Humana will subsidize the implementation cost of athenahealth's EHR service for 100 physician practices projected to represent 1,000 family and internal medicine physicians. Through care coordination and quality performance payments, participating physicians could earn up to 20% beyond their current fee-for –service payments from Humana. According to the two partners, this is the first time a national health plan has partnered with an EHR solutions company in support of the medical home.

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Catching Up With … Chad Boult, MD, MPH, MBA

Dr. Chad Boult is the Eugene and Mildred Lipitz Professor of Health Policy and Management in the Johns Hopkins Bloomberg School of Public Health. He directs the Roger C. Lipitz Center for Integrated Health Care and holds joint appointments on the faculties of the Johns Hopkins University Schools of Medicine and Nursing. A geriatrician for 20 years, his current research includes Guided Care, a multi-disciplinary model of primary care for older people with multiple chronic conditions. He talks about gerontologists, Guided Care, a hospital at home, and himself.

Chad Boult, MD, MPH, MBA

- Health and Aging Policy Fellow, Centers for Medicare and Medicaid Services, HHS (September 2009-September 2010)
- Eugene & Mildred Lipitz Professor of Health Policy & Management, Johns Hopkins Bloomberg School of Public Health (2001-Present)
- Faculty member at the University of Minnesota Medical School and School of Public Health (1990-2001)
- Member: Academy Health, Delta Omega Honorary Society, APHA, Gerontological Society of America, American Geriatrics Society
- Recognition for Guided Care : Excellence in Program Innovation Award, APHA (2008); Medical Economics Award for Innovation in Practice Improvement, AAFP (2009); Case In Point Platinum Award for Case Management Provider Program, Dorland Health (2010)
- Board certified in Family Practice, with an additional qualification in geriatric medicine
- MD degree from Wayne State University School of Medicine, MPH and MBA degrees from the University of Minnesota

Medical Home News: *You're about to finish up a year as a Health and Aging Policy Fellow at CMS. Tell us about that.*
Chad Boult: By early 2009, I had come to realize that improving large systems of health care requires more than good ideas and rigorous research: new public policies are also essential. Then along came the opportunity to learn about the implementation of federal health policy during a year as a Health and Aging Policy Fellow (funded by the Atlantic Philanthropies). I have been working at CMS, focusing mostly on the Office of Research, Development and Information (ORDI), the Center for Medicare (CM), and the new Center for Strategic Planning (CSP). Several top leaders at CMS have welcomed my perspectives as a clinician, researcher, and health care innovator as they prepare to implement health reform.

Medical Home News: *We hear all the time about the shortage of primary care physicians, and rightly so. But with the arrival of the Baby Boomers, don't we have a raging shortage of gerontologists? And is anyone worrying about that?*
Chad Boult: We've known for decades that the "baby boom" generation (the "silver tsunami") would swamp the US health care system when it reached old age. The Institute of Medicare and several expert panels have recommended training legions of geriatricians and primary care physicians to meet the coming needs for good geriatric care. Unfortunately, these recommendations have gone unheeded. We train only about 300 geriatricians per year, and medical education for primary care and specialist physicians at all levels (medical school, residency, and continuing education for practitioners) is only beginning to strengthen its geriatrics content. With the first baby boomers turning 65 in a few months, leaders of all the relevant stakeholders (educators, specialty societies, licensing boards providers, payers, businesses, and consumers) need to get serious about requiring competency in geriatrics throughout our medical education system.

Medical Home News: *At the Lipitz Center, with support from the John A. Hartford Foundation, you have built an impressive set of tools for physician practices interested in the Medicare Medical Home Demonstration (MMHD). Can practices access these resources now to help them in a medical home transformation or must they wait for CMS to roll out this initiative?*
Chad Boult: The Hartford Foundation foresaw the need for tools to help practices become medical homes and it partnered with our team at Johns Hopkins to create this assistance. The four tools that are available now include: 1) a practical implementation manual, 2) a nine-module online course for physicians and other practice leaders, 3) a 40-hour online course for registered nurses, and 4) a patient orientation booklet. These tools, which emphasize the "Guided Care" type of medical home for high-risk, high-cost older patients, can be obtained now through www.MedHomeInfo.org.

Medical Home News: *Your Guided Care model has won accolades for improving quality of care and the quality of both the provider and patient experience. Is it also passing the new acid test of "bending the cost curve" by generating net savings?*
Chad Boult: Complete information about how the Guided Care medical home works, as well as the awards it has won and the peer-reviewed articles about its outcomes, are available at www.GuidedCare.org. Early data from a recent, multi-site, randomized controlled trial have shown that Guided Care: improves the quality of chronic care, improves physicians' satisfaction with chronic care, reduces family caregivers' strain, produces high job satisfaction of nurses, and produces a trend toward lower net health care costs. Reductions in patients' use of hospitals, skilled nursing facilities and home health care, although not statistically significant during the first eight months of the study, saved enough money to cover the cost of providing Guided Care and to produce a net savings of $75,000 per nurse per year ($1,364 per patient per year). Details are in Leff, B. et al. Am J Manag Care 2009;15(8)555-559. Data analysis and reporting for years two and three are underway now.

Medical Home News: *One of the interesting research and demonstration projects that the Bloomberg School of Public Health pioneered was the "hospital at home" – which sounds like the ultimate "medical home". Tell us a little bit about that concept.*
Chad Boult: Hospital at Home (HaH) is a care model that provides acute, hospital-level care in a patient's home as a substitute for an acute inpatient hospital admission. A national demonstration showed that, compared with traditional acute hospital care, HaH was associated with fewer clinical complications, greater patient and caregiver satisfaction, lower caregiver stress, better functional outcomes, better provider satisfaction, and lower costs.

Medical Home News: *Finally, tell us something about yourself that few people would know.*
Chad Boult: My career in health care for older people may have taken root when I was a 13-year-old boy delivering newspapers daily to the frail old residents of low-income room and board facilities in Sault Ste. Marie, Michigan. It certainly came to fruition this year, during which I have had wonderful opportunities to help improve health care for almost 50 million older Americans.