Extending the Walls of the Medical Home: How Mobility Will Permanently Disrupt Healthcare Delivery

By William C. Thornbury, Jr., MD

The culture that shops online, banks online, buys books and movies and music online, will conduct a portion of their healthcare online. The question is, “With whom will they conduct it?”

Wm C. Thornbury, Jr., MD -- HiMSS 2013

Where Did Things Go Wrong?

About 150 years ago, physicians delivered care to their patients on horseback. As time and technology progressed, the traditional medical clinic developed to provide this service more efficiently.

Today, in the midst of the Internet era, we seek care in the same manner that our grandparents did ... in chronically congested medical offices. Care delivery is dysfunctional. The largest portion of our population is retiring at 10,000 a day -- demanding more (not less) resources.

By 2020, it is estimated that the United States will have a shortfall of nearly 100,000 physicians -- half being primary care. Simply put: our current of healthcare delivery is impractical for the society in which we now work and live. In point of fact, it is broken.

Building on the PCMH Momentum: The Primary Connection

By Thomas J. Foels, MD, MMM, and Pamela Menard, NP, MBA

Primary care is in crisis: physicians need to see more patients in less time, they have added pressure to stay current with an overload of information in a medical environment that is increasingly more technical and complicated, and they struggle to keep their practices afloat in the face of declining revenues and increasing costs.

Independent Health believes the most sustainable solutions to address the cost challenges facing our health care system start with the primary care physician and involve improving the quality of care, which will lead to lower cost trends in the future.

A not-for-profit, regional health plan based in Buffalo, N.Y., Independent Health has helped lead the development of innovative programs that are designed to improve access to affordable, quality care. Our company was among the nation’s first health plans to develop a pay-for-performance program which offers monetary rewards to physicians for providing members with proactive, high quality care.

We were also the first health plan in the country to partner with physicians to embrace office redesign and clinical systems improvement through the Idealized Design of the Clinical Office Practice (IDCOP) program.

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In This Issue

1 Extending the Walls of the Medical Home: How Mobility Will Permanently Disrupt Healthcare Delivery

1 Building on the PCMH Momentum: The Primary Connection

2 Editor’s Corner – Common, Chronic, and Preventable: Early Childhood Caries

3 Community Clinic Recognizes ACA Medicaid Enrollment Begins with Engagement and Screening

9 Thought Leader’s Corner

11 Industry News

12 Catching up with ... Allan Goroll, MD, MACP

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continued on page 4
Editor’s Corner

Raymond Carter, Senior Editor, Medical Home News

We continue our short commentaries on key issues and lessons associated with the medical home transformation journey with a piece from Dr. Rob Compton on children and dental caries this month.

Rob Compton, DDS
Executive Director
The DentaQuest Institute
Westborough, MA

Common, Chronic, and Preventable: Early Childhood Caries

Dental disease is the most common chronic childhood illness - five times more common than asthma. It is almost 100 percent preventable, yet the most aggressive form, early childhood caries (ECC), is often left untreated leading to a need for surgical intervention.

Dental disease is a bacterial infection spread from caregivers to their infants during the time that first teeth are erupting (seven- to 36-months old). When left untreated, it can result in ECC in very young children (one- to six-years olds). Frequently, these children come from low-income backgrounds with lower levels of maternal education. The earlier the child contracts the bacteria, the more likely he/she will develop ECC, which is painful. If severe, the toddler can lose teeth or require extensive surgery for root canals and stainless steel crowns. Children with ECC have problems eating, delays in speech, and even diminished self-esteem.

In many cases, the problem is usually not brought to the attention of a dental care professional until extensive disease has set in and even after surgery, many children return within a year (23-57 percent return within six-to-24 months) with new disease and needing additional surgery. The disease comes back because the surgery treats the symptoms, not the factors contributing to the disease.

So the challenge is to help children avoid ECC and reduce the need for surgical intervention, whether in a dental office or a hospital operating room. The DentaQuest Institute has been working with hospital dental clinics at Boston Children’s Hospital and St. Joseph’s Hospital for Specialty Care in Providence since 2008 to break the surgical cycle that has trapped so many families. We started by enrolling 450 children in a pilot study that first treated ECC surgically and then educated the caregivers and families on how to stop cavities and prevent new ones. We put equal emphasis on clinical intervention, caregiver education and more frequent visits with dental care teams. And it is working -- the proportion of high risk children has declined with consecutive visits, the number referred to hospital operating rooms has declined by 36%, and the number developing new decay has declined by 28%.

The success of the pilot led to the "Early Childhood Caries Initiative" in which seven dental clinics in hospitals and safety net dental programs in community health centers across the U.S. are implementing and refining the protocol, and success here has led us to expand the project further to up to 30 sites. We are now seeing cases where the oldest child in a family had severe ECC but because of education and self-management instruction, younger siblings are healthy, happy, and cavity-free.

A number of safety net community health centers that are medical homes either have dental care on site or have regular referral relationships in the community, but dental care is too often not part of the "medical neighborhood" for PCMHS or the ACOs for which they are the foundation. This is a critical flaw in our health care system. I urge the medical home community to reach out to their dental "neighbors" and especially to do so on behalf of children who are at risk for ECC.

Dr. Compton can be reached at Rob.Compton@greatdentalplans.com.
Community Clinic Recognizes ACA Medicaid Enrollment Begins with Engagement and Screening

By Ankeny Minoux and Steven Abramson

A key challenge for those operating medical homes will be how to get Americans who are eligible for Medicaid, as well as other public and private programs, enrolled and connected with programs that will cover their health care needs. One forward-thinking community clinic, the Community Health Alliance of Pasadena (ChapCare), is doing just that.

Reaching out to Patients. ChapCare provides more than 55,000 medical, dental, and behavioral health visits annually in Pasadena, CA. The organization is well-known in its community and is one of the more progressive clinics in California, often incorporating technology to create efficiencies and ensure better patient care. ChapCare recognized that an important first step to helping its Medicaid-eligible populations was to understand the different processes needed to enroll members, the obstacles it might face, and the solutions available in the market.

Enrollment is a Three Step Process. One of the first steps any organization must understand about the ACA is that there is no magic button to push for enrollment. It is a complex process that includes:

1. **Screening** – Patients need assistance with readily identifying which program/s they may qualify to receive. For many community clinics, it could be Medicaid, but it could also be a county program to help single pregnant women, a displaced worker, or an immigrant awaiting legal status.
2. **Eligibility** – Signing up for a plan or program is often complicated and time-consuming, as it may involve providing verification of income, proof of residency, and proof of identity via a driver’s license or birth certificate (a process that can be very daunting for many underserved populations).
3. **Enrollment** – Important to providers, this ensures patients enroll and claims are compensated by third party payers.

There are companies that assist with eligibility, but often the first two steps are the most difficult. They often involve reaching out to underserved populations, who are often transient and may not have easy access to the eligibility verification materials and who need guidance and enrollment assistance.

Reasons for Potential Lack of Enrollment. The transient nature of some Medicaid populations also makes traditional marketing and outreach difficult. Clinics in some communities must deal with concerns from immigrants who are unsure if they qualify. In states such as California, targeted populations also speak many languages, creating translation needs. Plus, in many Medicaid populations, food, clothing, and shelter often take precedence over worrying about health care, unless the person has an acute situation. It is common for many people not to enroll until it is completely necessary, i.e., they become sick or injured, or until it dramatically impacts their pocket book.

ChapCare understood all these issues and recognized, most importantly, that the first step was simply to connect and engage targeted populations. They identified two options for reaching potential patients: (1) as people came into the clinic and (2) directly on the street -- where people lived and worked. The ChapCare team turned to technology to help address its challenges. In the clinic, office staff have access to cloud-based software featuring a quick questionnaire and database of every state, county, and Federal health coverage program in California. When an uninsured patient comes into the facility, clinic workers walk them through five screening steps that cover residence, employment status, demographic information (age, sex, etc.), income, and special health conditions (since a person may qualify for other programs based on health).

To make it easier for patients, clinic workers also go out into the streets daily with laptops and tablets that can access the software and screen people before they come into the clinic. ChapCare’s leaders believe that the more screenings it can do in the field, the more efficient it will be once that patient walks into the clinic -- giving the staff more time to spend with patients. Clinic leaders also note that one value of a proactive approach to enrollment is that patients are much more willing to come to the clinic before a problem becomes acute when they know they have coverage. Having the ability to identify health coverage options quickly at point-of-care and enroll patients onsite gives community health centers more time to focus on patients’ health care needs.

ChapCare is also using their software vendor to provide a back-end tracking system that will help them track and follow-up on enrollment. This will allow them to be able to reach out to those patients who are still not enrolled and ask what they can do to assist with signing-up. While the program was just launched in early Spring, it is showing promising results. The clinic is now enrolling about 100 to 200 people per month.

Next Steps/Solutions. ChapCare’s example shows that there are steps the health care industry can take now to ensure better communication with at-risk populations. Strategies that should be considered include:

- Expanding community-based and highly-localized enrollment events, such as health fairs, booths at local events, and coordination with local employers;
- Using technology to provide outreach teams and navigators with tools to help people in the field before they come into the clinic or home;
- Ensuring that patients are tracked to determine when they enroll and when to follow-up if they don’t;
- Utilizing technology that can provide reports and record outreach efforts -- this is helpful for tracking, but also necessary for clinics that need to report on activities as part of effort to secure/retain grant monies; and
- Partnering with health plans and other organizations to help underwrite outreach and technology efforts.

continued on page 11
Building on the PCMH Momentum...continued

More recently, Independent Health has focused its efforts on implementing programs that address the systemic issues associated with access, quality, and patient satisfaction, starting at the primary care level.

**Patient-Centered Medical Home.** In 2008, Independent Health convened a Patient-Centered Medical Home (PCMH) Advisory Committee composed of community-based primary care physicians and Independent Health members. This advisory team critically examined the current state of primary care within the eight counties of Western New York, studied the underlying concepts of the PCMH model, and reviewed the National Committee for Quality Assurance’s Physician Practice Connections® - Patient-Centered Medical Home™ (PPC-PCMH) criteria. In addition, Independent Health collaborated with other health insurers nationally through the Alliance of Community Health Plans (ACHP), an organization representing regional health insurers that were similarly interested in exploring the PCMH concept and initiating pilot programs.

Aided by a multi-disciplinary team at Independent Health, the PCMH Advisory Committee developed a detailed blueprint for a comprehensive pilot program for Western New York primary care physicians, which was unveiled in January 2009. Independent Health invited 18 primary care practice sites to participate in our PCMH program. For nearly three years, we worked closely with these practices to help them redesign care within their offices, embrace a patient-centric approach, and enhance coordination of care with specialists, hospitals and other providers. These practices were diverse (family medicine, internal medicine, and pediatric sub-specialties), spanned geographies (urban, suburban, and rural), and included physicians in both solo and group practice. Upon conclusion of the pilot program, each participating practice had achieved NCQA PPC-PCMH recognition.

**The Primary Connection.** Although the PCMH program was successful in focusing on each individual physician’s practice, Independent Health was looking for a way to support population management through a care coordination model which encompasses the entire health care system. Partnering with a group of Western New York community physicians – many of whom participated in our PCMH program – Independent Health developed a new, pioneering approach that enables these physicians to influence patient care outside their practice. This physician-led alliance, called The Primary Connection, was launched in July 2012 and currently consists of 28 primary care practices, including 180 internal medicine, family medicine, and pediatric physicians who treat more than 200,000 patients.

Using PCMH principles as its foundation, the goal of the Primary Connection is to achieve the Triple Aim of better quality, improved patient satisfaction, and reduced costs by creating a virtual network of high-performing primary care physicians and specialists. To ensure full engagement and participation, the primary care practices involved in The Primary Connection have had to achieve or work toward achieving Level 3 NCQA PCMH Recognition, meet stringent quality/efficiency performance levels, and be open to making organizational improvements.

**Key Components of The Primary Connection.** These are the critical elements:

- **Learning Collaboratives.** Independent Health facilitates regular collaborative sessions and work groups led by physicians and attended by the practice care team members. During these sessions, physicians report on innovative initiatives, share best practices, and work on ways to improve patient care, satisfaction, and quality.

- **The use of Practice Care Coordinators (PCCs),** who are registered nurses employed by Independent Health. The PCCs are embedded within each primary care practice as an extended case manager. Using a team approach with the office practices to optimize a member’s care, the PCC plans, coordinates, and evaluates all options and services available to develop an individualized care plan for each patient. For example, the PCCs will arrange alternatives to hospital-based care when appropriate.

- **Development of primary physician – specialist physician compacts.** The Primary Connection physicians have been meeting with allergists, cardiologists, gastroenterologists, neurologists, and radiologists to establish patient treatment coordination and communication protocols, such as pre-visit consultations.

- **Quality and Efficiency Reports.** Each practice receives quality and efficiency reports, which the practices are using to identify potential improvement opportunities for patient outcomes, care coordination, and potential gaps in care. We have begun providing similar reports to cardiologists and other specialty groups, with the objective that all specialists who receive quality and efficiency reports share their summary information with The Primary Connection physicians.

- A unique reimbursement model that is based on pay-for-value and quality care rather than full reliance on fee-for-service... supports the physicians’ efforts to provide more team-based care, embrace alternative care pathways, improve access and capacity, promote preventive care, and foster inter-dependencies among The Primary Connection practices.

- **An annual “shared savings” incentive for reducing unnecessary medical costs.** If at year’s end the actual total spend on medical expenses is less than the expected cost, a percentage of that savings is distributed among The Primary Connection practices.

A unique reimbursement model that is based on pay-for-value and quality care rather than full reliance on fee-for-service... supports the physicians’ efforts to provide more team-based care, embrace alternative care pathways, improve access and capacity, promote preventive care, and foster inter-dependencies among The Primary Connection practices.

*continued on page 5*
Building on the PCMH Momentum…continued

Early Results. The Primary Connection is tracking and measuring success through four dimensions: the quality of care; patients’ satisfaction with their experience of care; a total lower cost of care for the health care system; and improvement of professional fulfillment by physicians and providers. Although we’re still in the early stages of this groundbreaking endeavor, many practices participating in The Primary Connection are already experiencing improved patient outcomes due to enhanced care coordination and better use of health care resources.

Figure 1 – PCMH/The Primary Connection: Quality of Care

A composite score is calculated from multiple variables to create a single measure to assess performance for a given area of focus. Composite scores were created to assess performance around diabetes, asthma, and obesity management.

The variables included in each of the composite scores are indicated in the following chart:

<table>
<thead>
<tr>
<th>Composite Measure</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>1st A1C completed, 2nd A1C completed, A1C at goal, LDL completed, BP at goal, DRE completed, foot exam completed, nephropathy assessed, GFR recorded, immunization completed</td>
</tr>
<tr>
<td>Asthma</td>
<td>Complete history, smoke exposure, assigned history correlates with history, right medication given severity, office spirometry, review of PF diary, immunization, asthma action plan, poorly controlled, not well controlled, well controlled, dosage</td>
</tr>
<tr>
<td>Obesity</td>
<td>BMI calculated, BMI overweight, BMI obese, BP, BP&lt;90, BP&gt;95, sweet beverages, fruits/vegetables, restaurant food, breakfast, portion control, physical activity, screen time, obesity, type II diabetes, hypertension, hyperlipidemia, cardiac event</td>
</tr>
</tbody>
</table>

While all practices have improved their performance on the composite scores, The Primary Connection practices have had a higher performance.

- **Diabetes** – The 2009 composite score of 6.1 increased to 6.6 in 2013 for The Primary Connection practices compared to an increase from 5.4 to 6.1 for the other practices.
- **Asthma** – The 2009 composite score of 6.7 increased to 8.1 in 2012 for The Primary Connection practices compared to a decrease from 5.7 to 5.2 for the other practices.
- **Obesity** – The 2009 composite score of 6.8 increased to 9.2 in 2013 for The Primary Connection practices compared to an increase from 5.8 to 8.2 for the other practices.

The composite scores reflect that multiple variables impact the ability to manage chronic conditions experienced by a patient; however, it is also important to note that we’ve seen significant improvement within many of the individual variables that comprise each composite score. For example, over the past four years:

- The number of Primary Connection patients with an A1C at goal has increased by 67 percent over the baseline for diabetes management.
- The number of Primary Connection patients with an asthma action plan has increased 100 percent over the baseline for asthma management.
- Assessment of physical activity has improved 178 percent over the baseline for obesity management.

continued on page 6
Building on the PCMH Momentum…continued

Two other accomplishments during the past 10 months also stand out. First, all of the cardiologists who currently partner with The Primary Connection physicians have agreed to share their quality and efficiency data, which speaks to increased engagement and transparency. Second, as a way to help reduce patient out-of-pocket costs as well as overall costs, Independent Health has encouraged The Primary Connection practices to prescribe generic medications when appropriate. From July 2012-April 2013, there was a 4% increase in generic prescribing among The Primary Connection internal and family medicine physicians. This is significant since a 1% increase in generic utilization can result in a savings of up to $1 million.

Future Objectives. In addition to achieving the Triple Aim, Independent Health and The Primary Connection have established other goals, including:

- Revitalizing and growing primary care. An insufficient number of young physicians are entering careers in primary care, as evidenced by a 2010 Association of American Medical Colleges study that estimated a nationwide shortage

continued on page 7
Building on the PCMH Momentum...continued

...of 29,800 primary care physicians by 2015. The Primary Connection practices are committed to providing more training and mentoring opportunities to medical and nursing students from area colleges and universities in hopes of encouraging them to choose primary care as their specialty.

- Promoting primary care physicians as leaders. Independent Health has invited 26 physicians from The Primary Connection to participate in a physician leadership development program. Over the next 18 months, these physicians will work with leadership experts to improve their leadership skills, teach them how they can influence and manage change and provide them with leadership opportunities.
- Developing a resource bank of pharmacists, nutritionists, diabetic counselors, social services, and other shared services for The Primary Connection practices to use. This will expand the physicians' capacity to serve the diverse needs of their patient populations by encouraging the use of medical care teams.
- The successes we have experienced in our PCMH program have positioned Independent Health well for continued success with The Primary Connection program. The Primary Connection represents a true opportunity for primary care physicians to lead the change in the way care is delivered, empowering them as the core in the health care delivery system. If we are to improve the patient's experience of care – including quality and satisfaction – and address the inefficiencies and redundancies that contribute to rising health care costs, it is imperative that we continue to find ways to strengthen the role of primary care for the future.

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Extending the Walls of the Medical Home...continued

A Lean Solution. After World War II, Toyota developed a management and production system that uses 8-Step problem solving to remove waste relentlessly as a means to improve service. This “Lean” system when applied to medicine offers a solution for the woes of our health system. As taught by Toyota, “True Lean” is a culture of championing the root-cause solution of a problem. Mistakes and inadequacies are applauded (not hidden). “Find a problem, fix a problem, and see that it never returns” is a common mantra. Toyota's system, refined over 60 years, is the scientific principle made actionable.

If the same problem-solving process were applied to improve the delivery of outpatient medical care, what might be its outcome? That was, indeed, the question that we asked ourselves three years ago. Our clinic was located in a rural portion of Kentucky. Like many clinics, we shared the problems of being unable to see our patients in a timely manner, and we could rarely accept new patients due to our burden. Having the fortunate opportunity to train under Toyota’s supervision, our problem-solving led us to a surprising conclusion: about 40% of our patients simply did not need to be in the clinic. These patients could be cared for safely and appropriately outside the confines of our brick-and-mortar clinic.

After reviewing the literature for the safety of online care (Munger, et. al.), and the experience of online care within the Medical Home model (Adamson and Bachman2), we felt comfortable applying it to our practice. Online care (e-Visits) worked well for about a week, then our first problem arose: care after-hours. There was simply no efficient way to contact the physician, login from an outside computer, open a program, go to another computer, open a file ... well, you get the picture. We then engineered the visit through a smartphone -- hence our second problem: how to attach relevant past medical history to the HPI and deliver an exceptional care plan with information back to the patient in under four minutes (what we deemed necessary.). An assessment is made, prescriptions communicated to the pharmacy, and a full instruction/disease-specific information sheet returned to the patient. The encounter takes about 15 minutes for the patient and averaged about 3 minutes for the physician. After two years, 95% of care requests were appropriate.

What Just Happened? Once you begin to conduct care through mobility, it becomes immediately apparent that you’ve opened a new generation of telemedicine – one that’s cheaper and more efficient than other previous forms. Telemedicine for the common man. We see it as a complement to current academic models that provide subspecialty care to disparate
Extending the Walls of the Medical Home...continued

populations. More importantly for us was the fact that it was efficient -- efficient enough to engage our physicians, meaning that for the first time, online care and telemedicine could be conducted within the Medical Home. Yes, the same Medical Home demonstrated by every study conducted to lower costs and improve outcomes would now become available to private physicians and health systems.

The last statement bears some examination. The business end of online care within the Medical Home is this: not only can minor acute care be provided online, but our study demonstrated that moderate acute care and stable chronic disease care (the latter representing 75% of the health dollar) could be safely provided as well.

Our two-year examination revealed that in a fee-for-service model, clinic capacity improved 15% -- that is, an extra hour each day to add value. Further, the per-capita cost of care decreased 15% -- critical for health systems struggling on a 1-2% margin. Most importantly, surveyed patients frankly loved it. To restate: we provide care in less time, using less resources, and patients actually prefer it.

Our model estimates that in outpatient care alone, the United States can save $30 billion per year. It wouldn't be difficult for a medical economist to make the extrapolation based on using this tool for hospital discharge follow-up since we know that a phone follow-up from a nurse coordinator following discharge can reduce hospital readmissions by 25%. Applying the technology to mobilize non-reimbursable ED care into primary care clinics (which would now have capacity) would provide both short and long term savings. Other portals, such as, palliative care, home health, and long-term care are equal channels for cost savings. Most importantly, the cost to industry for lost time, talent, and productivity could be estimated. Indeed, this new delivery model has the intention of bending the healthcare cost curve for the first time. Our medical system is transitioning from the model of Blockbuster to Netflix.

Implications. Mobility in online care is one of the rare times when disruption improves each aspect of the health system. Patients can receive care from their own provider anytime, anywhere. Medical providers increase access, lower liability in contrast to undocumented phone calls, and retain compensation for their intellectual work. Health systems can improve revenue from clinics, reduce readmissions, reduce ED misuse, and can now stake a claim to the most valuable real estate in healthcare: the peripheral. In essence, they have a communication tool direct to their patients. Employers will see less absenteeism and presenteeism (coming to work ill) and ultimately stabilize insurance costs. Third party insurers will see less acuity and lower costs, allowing them to assess risk (the same can be said of ACOs). Lastly, governments can increase access, lower cost of care, and make the medical workforce more efficient.

Market displacement may occur for retail clinics -- be they onsite or virtual. Also, traditional first-generation telemedicine models may have to change to account for the involvement of a patient's primary care physician, as well as medical specialties, dentists, and allied health professionals.

The power of true mobility in health delivery might be condensed into a phrase borrowed from Clayton Christian's, The Innovator's Prescription. Discussing how a disruption within the least profitable part of an industry ultimately trickles-up to affect the entire system, he used the example of rebar in the steel industry. In healthcare, this translates to, "We can make a profit on Medicaid/Medicare." And with this, our entire health economy changes.

Now What? Making medical care mobile and efficient, in one fell swoop, expands the Medical Home, lowers global costs, provides an immediate solution to the healthcare manpower shortage, and meets the goals of the Triple Aim. ... Now, what is required is leadership from responsible governments, policy makers, payers, and health systems to create scalability.

Dr. William C. (Chuck) Thornbury, Jr. is the founder of mevisit – www.mevisit.com – and a practicing physician in Glasgow, KY. He may be reached at wct@mevisit.com .

References
Thought Leaders’ Corner

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, write to Editor@MedicalHomeNews.com.

Q. “PCMH transformation is hard and requires resources, but what about sustainability? What resources are needed to sustain PCMH changes? Have you seen or experienced any back-sliding into old habits, e.g., ‘We used to have some doc around here who was keen on that but she’s gone now...’ ”

“Backsliding into a traditional appointment based model of care is easy if the continuous care coordination process is not rewarded. There must be a financial basis for the PCMH to continue. Just because it provides better outcomes is not enough. If the finances remain ‘fee-for-visit’, the episodic visit-based care will endure.”

Joseph E. Scherger, MD, MPH
Vice President, Primary Care & Academic Affairs
Eisenhower Medical Center
Annenberg Center for Health Sciences
Rancho Mirage, CA

“‘There are two responses to the question. First are those who have seen the Medical Home as meeting Meaningful Use criteria. They are often ‘stuck’ in the challenge of how to make their IT system user friendly and efficient -- the patient-centered concept is secondary. If not back-sliding, their attention is being diverted.

Second are those who have engaged patients and staff and are seeing the outcome results of improved quality (satisfaction and wellness) and decreased costs. The challenge for these medical groups is engaging more of their patients as partners in their care and expanding the model to more of their patients. In these clinics, the train is not stuck but moving down the track.”

Sam J.W. Romeo, MD, MBA
President and CEO
Tower Health & Wellness Center
Turlock, CA

“Let’s be perfectly clear. The new model for the practice of primary care, now popularized in the term ‘patient centered medical home’ is really about advancing the organization, financing, and conduct of primary care services: to be more service oriented for patients; to get better results for patients; to improve revenue for practices; to save money for the society at large; and to offer a positive work environment for those who are called to care for people regardless of the apparent reason for which they seek help. This is a long way to say we must increase value for patients and figure out how we can accomplish that in a sustainable way.

What seems to be hard is change. We all like the status quo because it is known and comfortable. Without change, we do not have to worry about predicting outputs based on inputs because we have experience that enhances predictability.

It is hard to understand why medicine insists on financial support before attempting innovation when other industries routinely innovate to assure financial support.

Digging the Panama Canal by hand was hard ... transforming to a more effective and efficient model of care that serves our patients with quality, reliability, and a high level of service will be the new entry level effort.”

Bruce Bagley, MD, FAAFP
Interim President and CEO
TransforMED
Leawood, KS
“The transformation to a PCMH is complex, typically involving significant workflow re-engineering and resource reallocation. Once those changes are put in place, the system should perpetuate itself. Along with care measures and outcomes themselves, processes should undergo periodic re-evaluation to assess efficacy and efficiency. If new members are added to the PCMH team, or replace a departing member, those individuals need to be coached on the meaning and the value of the PCMH, as well as all the processes and procedures required to achieve this model of health care delivery.”

Edward Rippel, M.D.
Solo Practitioner
Quinnipiac Internal Medicine, P.C.
Hamden, CT

“We experienced two related sustainability issues -- one financial and one operational. Our PCMH was partially funded by a pilot program, and when it was completed we did not have the revenues to continue our innovative programs and the additional salaries. Our providers increased their work hours to cover the deficit. Hopefully, real payment reform will begin before we burn out. Secondly, we have been providing such comprehensive care that the providers found it difficult to complete all their tasks consistently. We stopped monitoring our performance measures as rigorously as before. This was the result of staff changes, registry inadequacy, change fatigue, and the implementation of new innovations. We took a step back, reaffirmed our vision and priorities, reassigned responsibilities and reorganized our team meetings, and are now enthusiastically back on track. Both of these issues are direct results of inadequate payment for the PCMH.”

R. Scott Hammond, M.D., FAAFP
Associate Clinical Professor, University of Colorado School of Medicine
Medical Director, Westminster Medical Clinic,
Westminster, CO

“In order for patient focused services to be prioritized -- and that is the key phrase as there is plenty of money in the health care system; how to spend it is a choice -- there must be a correlation between investment and return for health, not medical care. The current inefficient, costly, poor health outcomes system developed through creating incentives for ROI in that system. No withholds or punishments and little investment risk got us to where we are today. So we need to create incentives for health. I like our Care Coordination model because: (a) it puts patient support services in an integrated primary care setting that is parallel to the direct delivery system and not within the medical model, thereby allowing coordination of care at the primary care level but also focusing on those non-clinical reasons for poor health; (b) it creates a bottom line for keeping people healthy separate from the secondary and tertiary care systems thereby reducing conflicting financial incentives caused by reduced utilization; (c) it finances rather than funds (i.e., grant, budget allocations) patient support and community health changing it from a cost to a revenue center; and (d) it is accountable with 100% case review and payments are based on meeting milestones of service.

Resources for sustainability include financing strategies such as PMPM without risk, and with bottom line opportunities for patient support systems that are accountable and outcomes based. With regard to back-sliding, nothing is ever 100% anything.”

Charlie Alfero
Executive Director
HMS – Center for Health Innovation
Silver City, NM

“At the very least, the same amount of work, resources, and attention is required to sustain a PCMH as is needed to start a PCMH. Without constant vigilance, other worthwhile projects as well as change fatigue may act to dilute the gains of a medical home. My recommendation is to follow the plan that made the practice a PCMH in the first place: strong leadership to make the PCMH a priority, working groups who meet regularly to develop strategy and follow-up, and all others to ‘own’ the medical home.”

George Valko, MD
Gustave and Valla Amsterdam Professor of Family and Community Medicine
Vice-Chair for Clinical Programs, Department of Family and Community Medicine
Jefferson Medical College of Thomas Jefferson University
Philadelphia, PA
Industry News

Special Annals Supplement on Medical Home Issues
The May Annals of Family Medicine published Transforming Primary Care Practice, a supplement with the results of 14 AHRQ projects looking at medical home transformation.

Primary Care Doctors Still Waiting for Medicaid Pay Bump
Only Massachusetts, Michigan, and Nevada have implemented the two-year raise in Medicaid payments for primary care that was to take effect nationally on January 1. Late publication of the CMS implementing rule has created delays and frustration.

Aetna Launches New Medical Home Program in New York
Aetna will provide quarterly coordination of care payments to 200 NCQA-recognized PCPs as part of a new PCMH program.

Community Clinic Recognizes ACA Medicaid Enrollment…continued

Act Now. The next several months present many challenges and opportunities to those in the healthcare industry seeking to reach out to the uninsured. Much will be learned as we all work together in a new system. Programs that provide information, foster education, and create efficiencies will be an important part of the process.

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Catching up with … (continued from page 12)

Medical Home News: One of your many hats is serving as a consultant for practices on payment issues. What kind of issues are you seeing with them? Allan Goroll: Conversations focus on how to move away from fee-for-service; however, most practices and clinicians remain organized and focused on maximizing the number of face-to-face visits (the basis of FFS payment). While many are moving towards medical home structures and their networks are developing information systems to help coordinate and monitor care, they have yet to commit to fundamentally changing payment. They are not sure how to risk adjust or measure and reward performance. Many are reluctant to change because fee-for-service is what they know and do well.

Medical Home News: Most people would agree that the key to long-term health reform is really, really good primary care, be it medical homes or the ACOs on which they are built or a strong primary care safety net. But it always seems to come down to payment. With a dysfunctional Sustainable Growth Rate (SGR) formula, a RUC tilted toward the specialties, a temporary-only bump in Medicaid primary care pay, and commercial insurer pilots that don’t cover the full cost of care coordination, how will we get to a point where primary care is truly valued and newly-minted doctors are choosing it over the sub-specialties? Allan Goroll: Let me share with you an anecdote that highlights how change might come: a student/resident champion of primary care at Harvard upon completion of training joined an innovative group practice only to find that he was to be paid by the number of RVUs he generated. He promptly cut back his number of sessions, ostensibly so he could do his reform work nationally, but one has to wonder what he might have chosen to do under a different payment system.

The take-home message is rather simple: you cannot accomplish health system reform without payment reform. We are creating exciting new models of patient-centered primary care, but unless we change the payment mode, we are not going to recruit and retain the next generation of medical school graduates. Right now primary care is “cool” and applications to residencies are up for the first time in over a decade, but it remains a financial sacrifice (estimated at $3.5 million in foregone lifetime income compared to average lifetime specialty compensation).

We don’t need to make primary care financial compelling, but we do need to compensate people fairly, proportionate to the value they create and sufficient to enable them to do a good job. This won’t happen under FFS payment schemes, even if doctored up with management fees. I am confident market forces and the work-life/practice environment demands of an emerging new generation of primary care physicians and allied health professionals will provide a strong impetus for primary care payment reform. Patients will demand it as a necessary condition for access to personalized, high-quality primary care.

Medical Home News: Finally, tell us something about yourself that few people know.
Allan Goroll: My passion is sailing. I have been sailing on Nantucket Sound for more than 30 years with a dear friend in a small 16-foot wooden dingy which I built during residency. Until just before he died, Senator Kennedy used to blow past us in his gorgeous classic yacht Mya. He was a great sailor.

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Dr. Allan Goroll is Professor of Medicine at Harvard Medical School and Physician of the Medical Service at Massachusetts General Hospital (MGH). One of the pioneers of modern primary care, he started right out of medical school by creating his own primary care internal medicine residency at MGH, the first of its kind in the nation. Widely published and recognized throughout a long career, he still serves as a practicing primary care physician in Boston. He talks about how he got started as a champion of payment reform, the pros and cons of pay-for-performance, the nature and pace of performance measurement in primary care, the need to get off the “cocaine” of fee-for-service payments, and himself.

**Medical Home News:** Paying for performance (or value-based purchasing as we tend to refer to it now) has been around for quite a while, with both its defenders and its detractors. What do you see as the principal pros and cons of a P4P/VBP model?

**Allan Goroll:** First, some principles about performance-based payment: Performance measures must be meaningful — scientifically validated and clinically meaningful to both patients and physicians. Payment should not be limited to static performance targets but should also reward improvement over time. Once a target is met, the performance payment should be folded into the base compensation so the practice isn’t penalized over time for achievement. The P4P payment scheme must be risk-adjusted to take into account actuarial risk and patient behavioral characteristics, obviating any perverse incentive to cherry pick patients. Finally, the amount of compensation provided by performance-based payment should increase markedly and proportionately to a practice’s ability to take on performance risk and the value created.

Current problems with P4P include reliance on too few parameters, focusing efforts on a limited number of areas and potentially distracting clinicians from other equally important elements of care. Some processes of care are given priority because they are simple to measure (e.g., periodic measurement of the hemoglobin A1c). This can result in misplaced efforts and patient inconvenience. Outcome measures should replace process measures over time. On the plus side, there are an increasingly large number of validated quality parameters to measure which are relevant to primary care.

**Medical Home News:** A propos of the recent dust up between CMS and the Pioneer ACOs over performance reporting vs. performance payment, how quickly should purchasers move providers to performance-based payment given that any set of metrics will be a somewhat imperfect measure of “quality”?

**Allan Goroll:** The pace of performance-based payment can and should parallel the development of performance-based measurement and the ability of practices to take on performance risk. The hard part is moving primary care steadfastly away from the distorting effects of fee-for-service payment. The problem is that doctors view FFS as the devil they know. Many distrust alternatives such as risk-adjusted comprehensive payment supplemented by performance-based compensation because it’s the devil they don’t know, reminding some of early iterations of capitation where the PMPM payment was too low and risk too high.

Increasingly, integrated networks are signing risk-adjusted global payment contracts with payers, with large bonuses for cost, quality, and patient experience. Ironically, many are still paying their primary care doctors and practices largely on the basis of fee-for-service, by volume and RVUs, perpetuating a counterproductive payment mechanism at odds with desired outcomes. The challenge for many is how to navigate the transition from FFS to a more value-incented payment system. Phase-in strategies make the most sense, paralleling the pace of a practice’s ability to assume performance risk. The magnitude of performance payment could be tailored each year to the amount of performance risk the practice is willing to assume.

**Medical Home News:** You have been a champion and an architect of payment reform for a long time. How did it all start?

**Allan Goroll:** About 15 years ago, as a medicine clerkship director I found many of my medical student preceptors going down the R.O.A.D. (Radiology, Ophthalmology, Anesthesia, Dermatology) of career choice. The pipeline for new primary care physicians was running dry. The practice environment was burning out my primary care colleagues; they were referred to as “providers” and “gatekeepers.” It became clear that the RUC’s RVU determinations were richly rewarding procedural specialists and starving primary care practices. I mentioned all this to Senator Kennedy on a Washington visit, and he predicted that nothing would be done until there was a crisis. Well, the crisis came. Fortunately and unbeknown to most, it has been addressed specifically in the Affordable Care Act, the writing of which we primary care advocates had the opportunity to contribute to as policy makers realized that health system reform requires the revitalization of primary care and fundamental payment reform. They asked what was needed, and we responded with the request for serious funding to stimulate widespread implementation of new models of practice and payment. The Center for Medicare Medicaid Innovation followed, supported by one billion dollars annually for ten years to transform practice and payment.

*continued on page 11*