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Medical Home NEWS

Including Oral Health in the Medical Home

By Steve Hurd, PhD, Executive Director, Marillac Clinic, Grand Junction, CO

Is oral health as essential aspect of primary care? Unfortunately, dental disease is a highly prevalent chronic condition in our country. Fortunately, primary prevention can occur at low cost while yielding high value for patients, providers, and the community. The practice of integrating care among medical, behavioral, and dental providers in a patient-centered medical home already exists.

An unfortunate outcome of the education and training of health care providers in this country is the carving-up of people and families into separate and discrete components that fragment their care. Most of us present our medical concerns in one facility, our dental concerns in another facility, and our behavioral health concerns in a third. The reimbursement system further promotes fragmentation by carving up separate benefits for medical, mental health, and dental care. Traditional health plans pay little or nothing for care coordination.

Thus, the burden of organizing comprehensive primary care falls on the patient and the patient's family. Although the medical home concept was described in pediatric literature in 1967, activation of the medical home model occurred as a response to this county's health care crisis. Most of us acknowledge that the current system of fragmented, inaccessible primary care is no longer sustainable. The patient's and family's voice also contributes to change. "We don't want the current system – we wanted to be respected and treated as human beings."

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In This Issue

ThedaCare's Lean Approach to Primary Care

By John Toussaint, MD, Founder and President, ThedaCare Center for HealthCare Value

Today's healthcare all too often is plagued with waste, errors, and high costs. As a result, the industry crashes the equivalent of a 747 jet each day, meaning about three hundred people die unnecessarily from medical errors, according to the Institute of Medicine.

These statistics are wholly unacceptable. Yet they are a direct result of disjointed care, where waste is rampant, clear communication is missing, and traditional barriers block staff collaboration. Our patients — and our fellow healthcare providers, who work in this environment each day — deserve better.

The solution isn't only about having electronic health records, more insurance coverage, or more advanced technology. Unless we fix the waste and errors first, all we're doing is developing different ways to pay for and perpetuate a broken system. Patients deserve a cohesive care experience that gets them better, faster and home, sooner, i.e. care that costs less and increases value. Lean healthcare helps us create this unique model. Manufacturers have used lean thinking for decades to achieve steady productivity gains, reduced defects, and improved customer and employee experiences. Imagine similar results in healthcare!

In 2003, ThedaCare began applying lean principles and tools to our care delivery processes in an effort to deliver better care. What emerged was a system-wide, continuous improvement initiative known as the ThedaCare Improvement System (TIS). We use TIS to reduce waste, eliminate errors and increase productivity in physician offices and outpatient centers, as well as our hospitals.

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Editor's Corner

Raymond Carter, Editor, *Medical Home News*

I have invited members of the *Medical Home News* Advisory Board to submit short op ed pieces for inclusion in this space. Other *Medical Home News* readers are welcome to do so as well. This month we feature a piece from Advisory Board Member Margaret Kirkegaard, MD, MPH. *Ed.*

Margaret Kirkegaard, MD, MPH
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The Many Sides of Care Coordination

By Margaret Kirkegaard, MD, MPH

As Joe Scherger astutely noted in last month's issue of *Medical Home News*, the essential feature of the medical home model can be summarized in two words: "care coordination". Clearly, we value "coordinated" care over "uncoordinated" care, but how do we define, measure, and pay for "coordination" in a way that ensures better health outcomes?

How do we define care coordination? For the elderly Medicare patient, care coordination may be selecting and tracking a pattern of referrals to various specialty providers to assist in the management of multiple chronic diseases. And for the impoverished young family, care coordination may be assuring adequate food for the family or arranging transportation for well-child visits. Are these all appropriate tasks for care coordination?

How do we measure care coordination? We can measure the presence or absence of a worker assigned to the tasks of care coordination and some of the activities associated with care coordination such as tracking referrals. Several accreditation bodies such as URAC, AAAHC, and NCQA are developing measurement sets for the medical home, but none of the measures have had widespread use so their ability to actually measure care coordination is still unknown.

How do we pay for care coordination? Care coordination will be more labor intensive for certain patients such as those with multiple co-morbidities, impaired mental capacity or challenging social needs. Should there be greater payment for degrees of care coordination? The now-tabled Medicare demonstration projects proposed to stratify the monthly care coordination fees based on the medical acuity of the patients. While such stratification appears equitable, will it enhance care coordination activities or outcomes?

Right now, most care coordination is paid for through a capitated monthly care coordination fee. However, we know from decades of experience that capitated payments do not always ensure that work is accomplished or outcomes are achieved. Because we haven't figured out a payment mechanism that drives outcomes, it would be unfortunate to add a whole new set of care coordination tasks to primary care and fall into the same patterns of poor outcomes. The vision of a health care delivery system that provides highly coordinated care is clear; the practical, immediate steps needed to get us to that vision are still murky.

They Are All Our Patients – Population Management At Carilion Clinic

By John Wendland, Colette Carver, FNP and John Peyton Taliaferro, MD

Carilion Clinic is a healthcare organization with more than 600 physicians in a multi-specialty group practice and eight not-for-profit hospitals. Headquartered in Roanoke, Virginia, Carilion Clinic and its 12,000 employees serve approximately 1 million people in western Virginia. The Department of Primary Care and Regional Medicine operates 35 primary care locations with 180 providers. A pilot site in Vinton, VA, was recognized at Level 3 in October 2009, five other sites are currently undergoing NCQA review, and ten more will seek recognition in September 2010.

As we began our transition to the medical home model in early 2009, our implementation team asked a series of fundamental questions regarding the project. Among them was a seemingly simple question: Who are our patients? Our team's response would have a profound impact on the direction our program would take. We determined that they are all our patients – not just the scheduled appointments that filled our exam rooms each day, but another universe as well, made up of patients who populated our physician panels, were often very sick, and rarely seen. The needs of these "invisible" patients would also have to be addressed.

Our pilot experience was essential in defining our approach to population management and preparing our department for its launch across multiple practices. Searchable patient information, vitals, lab and imaging results, med lists, problem lists, templates, and health maintenance needs were all readily accessible and captured in our EMR for pre-visit planning associated with active patients (see Table 1). We had developed decision rules for managing the invisible population, but found the execution of our intent to be labor intensive and less than ideal for system-wide application.

A technical team was assembled in early 2010 to improve the breadth and depth of our population registries and make them more user friendly. The improvement team's efforts resulted in a fully-realized process that efficiently and effectively identifies patients at risk who have been previously diagnosed with a Clinically Important Condition. Electronically generated lists of candidates for intervention are prioritized according to evidence-based criteria by the last clinical results available, the lack of a recent assessment, or the length of a patient's absence from the practice. For example, a diagnosed hypertensive with a blood pressure of 180/100 last recorded in 2008 would be sorted toward the top of the listing.

Care Coordinators - licensed nursing professionals embedded in each practice - generate the population registries monthly, review provider panel results with each physician, and contact patients according to their priority ranking. The coordinators are also trained to look down into provider schedules and make appointments when engaged with patients. After some early discussion about centralizing this process, we determined that the value of having professionals associated with a patient's practice, capable of assessing needs in real time EMR reviews and patient interviews, outweighed any efficiencies to be gained in an anonymous call center.

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They Are All Our Patients*...continued*

Table 1. Population Management Work Content

PROCESS	ELEMENTS	RESPONSIBILITY	TIME
PEAT Patient Education Assessment Tool	Assesses patient barriers to care and self-management	Nurse	1 min / patient
Medication Reconciliation	Interviews patient and matches data with EMR med list	Nurse	5 min / patient per visit
Mammography Focus	Creates candidate list from those scheduled for the next day; sends to Care Coordinator for inclusion in Pre-Visit Huddle preparation Schedules mammograms or retrieves results from external sources and scans into EMR	Front Desk Mammography Technologist, Nurse or Care Coordinator	5 min / provider per day 1 hr / day
Pre-Visit Huddle Preparation	Prints patient EMR snapshots Identifies patient prevention and health maintenance needs Identifies patients with clinically Important Conditions and current outcome status for key clinical indicators Identifies patients in need of counseling and self-management support programs	Nurse or Care Coordinator Nurse and Care Coordinator Care Coordinator Care Coordinator	5 min / provider per day 30 min / day 15 min / provider per day 15 min / provider per day
Pre-Visit Huddle	Review huddle prep data, align care team resources and assign tasks	Provider, Care Coordinator and Nurse	15 min / day
Care Plan Communication	Presents after visit summary documenting current history, treatment plan and objectives	Front Desk	1 min / patient
Patient Registry Maintenance	Generates sort of patients carrying a Clinically Important Condition diagnosis since the advent of the EMR (2008); ranks by priority protocol to determine the sickest of the sick; reviews data with providers	Care Coordinator	2 hrs / provider per month
Patient Registry Utilization	Uses prioritized listings to create call list; contacts patients via telephone; consults EMR in patient interview; schedules appointment directly	Care Coordinator	2 hrs / day
Discharge Follow-Up	Receives notice of patient discharge from hospital ED and in-patient services in real time via EMR; contacts discharged patients within one business day.	Care Coordinator	1.5 hrs. / day
External Communication	Provides medical records to patients and/or specialties and services outside the system	Front Desk	1 hr / day

Our rate of appointments made in response to coordinator interventions (Table 2) has been encouraging, and we attribute this to the patient contact method employed. Our current improvement project is directed at building outcome models for registry patients who resumed their association with the practice. By year's end, we will have sufficient data available from 16 practices to begin to determine if working the registries results in significantly improved patient outcomes and satisfaction over time.

In 2011, we plan on researching and addressing the behavioral and financial obstacles that keep patients from returning to a practice–even in the face of compelling clinical evidence to do so. As was demonstrated by our experience with population management, we feel we have only crossed the threshold of the medical home and look forward to our continuing transformation.

Table 2. Population Management Activity–April 2010

PRACTICE SITES	PRIORITY 1 CIC PATIENTS IDENTIFIED	PRIORITY 1 CIC PATIENTS CONTACTED	APPOINTMENTS SCHEDULED	% PATIENT CONTACTS SCHEDULED	IN-PATIENT DISCHARGE FOLLOW-UPS
Roanoke Metro (6)	1,084	656	281	42.8	398

Notes

1. The six Roanoke Metro practices are Blue Ridge, Brambleton, Colonial Avenue, Daleville, North Roanoke, and Vinton.
2. CIC = Clinically Important Conditions: Diabetes Mellitus, Hypertension, Asthma.
3. Priority 1 patients not contacted rollover to the next month's call list.
4. 4. In-patients receiving procedures such as colonoscopies are excluded from the discharge follow-up protocol.

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Including Oral Health...*continued*

There are medical home models that have developed in this country that do include oral health as an essential aspect of primary health care. Marillac Clinic is one. Since 1991, Marillac has integrated oral health care as part of its holistic approach to serving people.

Why include oral health as an essential aspect of primary care? The value proposition is that including dental care improves the health outcomes for patients and their families, and treating dental disease lowers the cost burden of treating other co-occurring conditions. Provider satisfaction also increases because providers now have ready access to dental consultation or dental services for their patients. How many of us are have experienced "life-as-we-know-it" coming to a screeching halt when stricken with acute dental pain? Is our only solution the one provided by the ER – receiving pain-relieving medication? What would a medical home do differently?

Ongoing dental care is more essential to good health than we realize. Mounting research-based evidence links dental disease with a myriad of health problems including endocarditis (inflammation of the heart and its valves), brain abscesses, complications for patients with diabetes, and a longer time for the body to heal wounds. Data also indicates that women with chronic gum disease during the second trimester of pregnancy are nearly twice as likely to give birth prematurely, leading to babies with significant health problems – extremely expensive to treat in a NICU.

Historically, the majority of dental treatment used an end-stage approach of surgically removing the source of infection (tooth extraction). Sadly, we still resort to end-stage treatment today as an acceptable solution. Would we be satisfied if the only foot care we offered a person with diabetes is amputation? The advent of root canals has enabled people to keep their teeth, but at an expense that is unaffordable for many, even those with dental insurance. Marillac works hard to provide root canals so patients will not lose their front teeth because this creates both high social cost and scarce employment opportunities for people who are embarrassed to smile.

Dental disease is now acknowledged as a chronic condition. It is the most common chronic disease in children, and dental pain is often cited as the most frequent reason why children miss school. Imagine trying to learn or take a test while experiencing dental pain…

The good news: Dental disease is one chronic disease that is completely preventable for most people.

PRIMARY PREVENTION: At Marillac, staff are highly engaged in two prevention programs:

1. The B 4 Babies Program assures that all pregnant women in the county are offered affordable access to dental care that assures their mouths are free from bacteria throughout the second and third trimester. Our clinicians have learned that mothers become activated once they understand their children do not need to experience dental pain (much more powerful than avoiding premature birth). Significant education occurs during demonstrating how bacteria can easily be transmitted from mother to baby via saliva. Mothers also learn that putting babies down with a bottle of water rather than a sugar-filled drink discourages the development of bacteria in the infant's mouth.
2. The Cavity Free by Three Program involves having Marillac's Associate Medical Director teach providers in family and pediatric practices how to apply dental fluoride varnish to strengthen enamel of young teeth. Applying sealants creates a barrier between bacteria and the surface of the tooth. Evidence demonstrates that prevention of colonizing bacteria forming on children's teeth during the first three years of life creates a natural flora environment that effectively fights colonizing bacteria throughout one's lifetime.

How can oral health care be integrated in the medical home? The process is highly similar to the way that behavioral health is integrated in the medical home. In other words, there is more than one path. But one essential characteristic is common to all successful programs – enduring leadership and a consistent commitment by staff to align clinical, financial, and operational processes. But one thing I've learned: dental providers by nature want to stay busy. The following examples from Marillac's experience are exactly these – examples of team-based and family-centered care. Other sites can learn from our examples, but I do acknowledge – you will feel growing pains.

SECONDARY PREVENTION: With respect to dental health, secondary prevention is keeping the teeth you do have. There is "no wrong door" at the medical home. Whether a medical, mental health, or dental provider receives a patient initially, standardized information gathering will yield a consistent and predictable interaction among the health care team. A medical provider can learn to identify "white or brown spots on teeth" that would lead to a dental referral. Having an open access model at all care sites within the medical home encourages immediate intervention, which reduces the likelihood of the issue becoming more complex and more expensive to treat. Prevent the dental "No Show."

TERTIARY PREVENTION: What happens when your patients are in line at 7 AM with a toothache? What services can a medical home provide if people present with no healthy teeth and cannot chew? Open access will decrease utilization of the emergency room.

FUNDING CHALLENGES: This is a challenge, but a worthwhile one. Medicare has no dental benefit. In Colorado, extraction (amputation) is the only reimbursable dental procedure for Medicaid adult patients. Marillac accesses considerable foundation funding. The clinic also employs a care coordinator to identify funding for individuals on a case by case basis.

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Including Oral Health *…continued*

PROMISING CLINICAL APPROACHES: USING SALIVA ANALYSIS TO DETECT CANCER. Researchers at the University of Texas are studying ways to identify protein markers in human saliva to for the early detection of cancer. Streckfus et al (2008) are studying how protein profiles in salivary secretions are altered by the presence of cancer. Young, healthy adults typically visit the dentist more often that a medical provider. Streckfus asks the obvious "Why not the dentist? Saliva analysis is a non-invasive, quicker way for detection."

A consensus now exists that behavioral health needs to be addressed in the medical home. Who among us will advocate for the inclusion of oral health in the medical home? Those of us who've been around the block a few times received many discouraging responses before health plans and providers acknowledged that the mind and body are connected. Now it's time to include the mouth and the teeth in patient-centered care. What may be perceived novel or unattainable today will be achieved tomorrow.

Steve Hurd, PhD, is Executive Director of the Marillac Clinic in Grand Junction, CO. He can be reached at Steve.Hurd@stmarygj.org.

ThedaCare's Lean Approach*…continued*

The results achieved by ThedaCare and other pioneers in the Health Care Value Leaders Network prove that lean is effective and sustainable. Since 2006, ThedaCare has saved more than $27 million from productivity improvements without laying off any of its 5,500 employees. So how did we do it?

Outpatient Overhaul

One key area in which we focused was the outpatient care delivered in our physician clinics. We needed to figure out how to improve the patient experience, while streamlining work for staff. To do so, we relied on lean planning tools like value stream maps, which outline the individual steps in our care process.

We needed to understand each of those steps in order to improve them. Our goals were to eliminate steps where patients saw no value and to achieve incremental improvements each day. In some cases, we involved our patients directly. We focused on attributes that would provide them with more value, including:

- Guaranteed same-day appointments in our physician offices for patients who call prior to 2 p.m. Those who call after 2 p.m. are scheduled for the same day or following morning.
- Access to any ThedaCare Physicians location, not just the one where their primary care provider is located.
- Extended office hours to better accommodate patients' busy schedules.

Perhaps the most notable change as a result of value stream mapping is our ability now to provide patients with same-day lab results and a written take-home plan of care at the end of their visit. Patients used to wait 2-5 days to get lab results because physician offices didn't have the needed equipment in house. Now, 75 percent of the time, we can provide patients with their lab results within 15 minutes — before the end of their physician visit. This quick turn-around led to higher customer satisfaction, especially among elderly patients and families with children, who no longer have to plan multiple visits to get their results.

Patients also appreciate the take-home plan of care they receive during their appointment. It includes medication lists, vital signs, notes on why the provider saw the patient for that specific visit, and when the provider wants to see the patient again. Our patients tell us they carry these summaries in their purses or wallets as an emergency list of allergies and medications. Another key improvement area involved our phone response and admission processes. Since a phone call often is the patient's first interaction with ThedaCare, it's important to make that experience a positive one. Our physician clinics currently answer 87 percent of calls within 20 seconds.

A second measurement of success with phone response rates is known as First Pass Yield, the percentage of calls that address the issue of concern during that first call. Prior to implementing our new delivery model, we only accomplished this 20 percent of the time. Now, staff address patient concerns 92 percent of the time during the first phone call (See Figure 1). This means patients experience fewer call backs and delays.

Once patients are on site, they benefit from improvement work on "middle patient flow," which measures a provider's timeliness for each patient visit. Across all locations, our physicians strive to start 85 percent of patient appointments on time. The improved efficiency means providers can now see an average of four patients per hour, instead of just three.

Patients also report that it feels like providers spend more time with them, without rushing them out the door for the next appointment. We also changed our admission process so that registrations are validated ahead of time over the phone, making it much faster to check in on site. Patients typically wait as little as 30 seconds to check in after arriving at the clinic. Although we've achieved significant success so far, we continue to publish daily and weekly information about areas in which we can further improve. To sustain these dramatic improvements, ThedaCare documents standard work and utilizes visual tracking boards to monitor progress.

Better Working Environments

In the same way that high-quality care leads to lower costs, creating a better patient experience also improves the work environment for physicians and staff.

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ThedaCare's Lean Approach...*continued*

Figure 1: *Lean tools like Value Stream mapping helped produce the following "before and after" results at ThedaCare's physician office in Kimberly, Wisconsin.*

New Delivery Model Kimberly Results

Measure	Baseline – Pre New Delivery Model	New Delivery Model – Dec. 2009	Comments
Safety Warfarin Compliance % within range/total INR's	80%	95%	
Quality Disease Management Disease management for the 5 measures in Comp	58%	93%	Plan of Care includes: 1. HM addressed 2. Future labs wait-listed or futured. 3. All follow-up appointments scheduled. 4. After visit summary printed, given and explained to patient.
Plan of Care- First pass yield % patients leaving with complete plan of care	20%	92%	
Service Patient Satisfaction Quality of time (top box questionnaire)	64%	84%	
Access I was seen when I wanted to be seen? (top box questionnaire)	60%	71%	
Timeliness Core Labs % turn-around time within 15 min	5%	75%	

THEDACARE

As part of our improvement efforts, we sought to increase physician efficiency by removing some of their burden for patient documentation. That way, physicians could spend more quality time with patients. Patient documentation is now done by medical assistants, and our processing efficiency has increased, thereby reducing potential billing delays.

Engaging Specialists

ThedaCare recently pursued a unique collaboration with local specialists to provide integrated, one-stop care. The multi-specialty ambulatory care center, known as Encircle Health, is composed of primary care and specialty physicians — from internal medicine to orthopedics to behavioral health to pharmacy.

By collaborating, we put the patient at the center of care and created a stronger healthcare model for our community. Encircle Health's approach reduces a patient's need to travel for care, creates efficiency through a single registration, and allows for same-day consultation with a specialist. We provide the best care possible with the least amount of stress and strain by providing patients with a single coordinated plan of care.

Reinventing Inpatient Care

The same attributes that are important in delivering high quality primary care also apply to hospital care. In 2003, ThedaCare began examining inpatient care as part of "Transforming Care at the Bedside," an initiative sponsored by the Institute for Healthcare Improvement (IHI) and the Robert Wood Johnson Foundation.

The tools provided by TIS helped ThedaCare's leadership and staff find innovative ways to reinvent and revitalize inpatient care, and led to the creation of our Collaborative Care approach. Collaborative Care represents an entirely new way of treating inpatients. It relies on the close collaboration of a physician, nurse, pharmacist, and care manager who guide the patient from admission to discharge, and closely monitor his or her progress against evidence-based care standards. Once we redesigned the care delivery process, we then developed new room designs that supported the care model.

So far, Collaborative Care has achieved remarkable results compared to traditional units (See Figure 2). We've:

- Eliminated admission medication reconciliation errors
- Increased patient satisfaction
- Decreased average length of patient stay
- Improved Centers for Medicare and Medicaid Services quality bundle compliance significantly

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ThedaCare's Lean Approach to Primary Care*...continued*

Figure 2: *Thanks to its Collaborative Care model, ThedaCare achieved dramatic improvements in inpatient quality, safety and satisfaction compared to traditional hospital units.*

Collaborative Care Results to Date

Measure	Pre-Collaborative Care (2006)	End of 2007	End of 2008	2009	Compares to non-Collaborative Care units 2009
Defect-Free Admission Medication Reconciliation	**1.05** defects per chart	**0.01** defects per chart (-99% vs.2006)	**0** defects	**0** defects	**1.25** defects per chart without RPh
Quality Bundle Compliance	**38%** Pneumonia (2005 baseline) **No baseline** for CHF	**100%** Pneumonia **92.5 %** CHF	**95%** Pneumonia **85%** CHF	**95%** Pneumonia **92 %** CHF	**83 %** Pneumonia (All or none bundle score) **90** % CHF (all or none bundle score)
Patient Satisfaction	**68%** rated as top box	**87%** (+30% vs. 2006)	**90%**	**4.85 on scale of 5** (revised tool Sept '08)	Not captured for other units.
Length of Stay*	**3.71**	**2.96** (-20% vs. 2006)	**3.16**	**3.01**	**3.19** days
Case Mix Index* Used top 16 DRG's that match across cc and non-cc	**1.08**	**1.12**	**1.11**	**1.13**	**1.37**
Average Cost Per Case* (using Medicare RCC)	**$5669** - fully loaded	**$4467** - fully loaded (-21% vs. 2006)	**$5849**	**$5567—fully loaded**	**$7775**

* Financial Indicators represent a subset of the patients to demonstrate impact of the delivery model. Excluded from both baseline and pilot are: observation patients, ICU patients, and LOS >15 days. Pilot numbers includes: Admits from ED to Unit, or direct admits to unit. 2006 is updated baseline.

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ThedaCare is spreading Collaborative Care, as well as the private patient room design that supports it, to all units at two of our hospitals.

Learning to Be Lean

Transforming an existing culture is the most important and most challenging aspect of implementing lean in healthcare. People often are resistant to change, so we support them with training and follow-up. Employees preparing to work on Collaborative Care units, for example, complete more than two weeks of classroom work and shadow their colleagues in real-time Collaborative Care situations. It is a great advantage for staff to observe and practice improvement concepts prior to jumping into the new model.

Moving Forward

ThedaCare's efforts have earned national recognition, and we believe our success demonstrates the benefits of applying lean in healthcare. We are driven by a strong belief that we must change to sustain our obligation to care for our community. The real reform in health care will come when we learn what manufacturing learned thirty years ago and when we create the same reliability for our patients that lean manufacturers have achieved in products. This will move us toward better, more affordable care and a healthier nation.

John S. Toussaint, MD is CEO emeritus of ThedaCare and CEO of the ThedaCare Center for Healthcare Value. He may be reached by phone at (920) 831-1960 or by email at john.toussaint@thedacare.org.

SAVE THE DATES – TWO MORE "CAN'T MISS" MEDICAL HOME AUDIOCONFERENCES

Wednesday, June 30, 2010 --- 1:00pm to 2:00pm Eastern
"What if a Health System Decided to Create 'Ideal' Primary Care?"
Joseph E. Scherger, MD, MPH
Vice President for Primary Care, Eisenhower Medical Center, Clinical Professor, UC San Diego
Register now at www.medicalhomeaudioconferences.com/MedHome20100630/index.html

Wednesday, July 28, 2010 --- 1:00pm to 2:30pm Eastern
"The Horizon Blue Cross – New Jersey AAFP Medical Home Partnership"
Featuring Health Plan, NJ AAFP, and Physician Practice Leaders
Watch for details at www.medicalhomeaudioconferences.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. "So long as we have a fee-for-service system, if the patient-centered medial home is doing a good job of reducing ER visits and hospitalizations, what is the value proposition for the hospital or health system in supporting a medical home given reduced hospital revenues?"

"Reduced hospital revenue only happens in a traditional fee for service market. Hospitals and health systems must become accountable care organizations providing value to those who pay for care. Avoidable emergency visits and hospitalizations are waste, not value. New financial arrangements like bundled payments are likely to emerge soon and will reward greater quality and efficiency of care. The PCMH model provides that at the office practice level. Forward thinking hospitals will realize that such value is their future and this redesign of care takes time to develop."

Joseph E. Scherger, MD, MPH
Vice President, Primary Care
Eisenhower Medical Center
Eisenhower Argyros Health Center
La Quinta, CA

"Ensuring that patients receive the right care at the right time by the right provider is a key precept of the advanced medical home. For frail elderly patients with multiple chronic diseases with predictable exacerbations which are amenable to proactive management, this is particularly critical. These complex patients with variable baseline status are poorly served by episodic care via emergency departments, and acute hospitalizations often merely create additional opportunities for errors in transitions. We have found that 90% of the time, by focusing on maximizing value for the patient, the overall cost is reduced while quality is improved.

For a hospital, the value of reducing unnecessary emergency department visits and inpatient stays for these patients revolves around appropriate deployment of resources. Emergency departments are not designed to care for moderate exacerbations of multiple chronic diseases and do not have the appropriate cost structure, nor resources, to effectively optimize the treatment. The complexity and variable baseline coupled with this often results in an admission to another service not optimized to care for these patients because of a lack of knowledge of the patient, longitudinal history, and family and community resources available to support them. This then diverts resources and attention from patients that are better suited to acute care hospital management, results in throughput issues as these patients have problematic discharges, clogged emergency rooms, and ultimately displacement of higher DRG patients with a more clearly defined end point, such as cardiac procedures. Ultimately, as the health of these chronic patients improves, the greater health and longer life may mean that more receive restorative therapy such as joint replacement. By reducing the unneeded visits to the high cost resource platforms, medical home will allow facilities to more effectively deploy resources and control their costs and focus their efforts on providing value in those areas of the system to which they are uniquely suited."

Thomas R. Graf, MD
Chair, Community Practice Service Line
Geisinger Health System
Danville, PA

"In the current hospital payment system the value proposition for building PCMH's that reduce ER and hospital use includes: 1) focusing on the segment of the market with a low/no reimbursement (i.e. Medicaid, charity care, and self-pay) or long lengths of stay (i.e. complex Medicare patients); 2) building internal capacity for the future moment when the reimbursement system stops rewarding episodic, fragmented, and uncoordinated care; and 3) seizing the opportunity to attract and hire talented primary care providers before the primary workforce shortage increases. Resilient organizations don't gamble the future of their organization on the current business model continuing unchanged. It's clear that unsustainable increases in healthcare spending will push the nation towards a future of changes in reimbursement to favor integrated and organized models of care. It's important to lay the groundwork now for the new skills, activities, and workforce that will be necessary."

Jeffrey Brenner, MD
Executive Director/Medical Director
Camden Coalition of Healthcare Providers
Camden, NJ

*T*hought Leader's *C*orner

"First and foremost, if implementing the Patient Centered Medical Home (PCMH) is the right thing to do for patients, then health systems need to do it, regardless of the impact on revenue. That's our fundamental mission – to improve the health of our patients. We must hope that over time the reimbursement system will recognize the value of incenting healthcare providers to keep patients healthy and out of the hospital as much as possible.

The PCMH model can also contribute to overall health system revenue growth by increasing patient satisfaction, supporting referrals to system specialists, and increasing staff productivity and effectiveness. Thus, the growth brought about by the impact of the PCMH medical home model of care will more than offset the reduction in some utilization by the present population being seen. Since the model is ultimately more efficient, the costs associated with providing care to the new patients should be less on a per patient basis."

Lee R. Campbell, MD
Vice President, Ambulatory Quality
Clarian Health
Indianapolis, IN

"If the Patient Centered Medical Home (PCMH) concept reaches its fullest potential, we anticipate ambulatory care will be improved, which will result in a decreased need for the inpatient hospital system for medical conditions. These ambulatory care sensitive conditions currently represent low reimbursement that often does not cover the total cost of caring for the patients. These are also the same patients with frequent readmissions that may not be reimbursed at all. In addition, PCHM allows patients with no insurance or Medicaid to have a home for primary care as opposed to using the more expensive hospital delivery system. This positively impacts non-reimbursed care for hospital systems."

Mary Ellen Benzik, MD
Medical Director
Integrated Health Partners
Battle Creek, MI

"The medical home model has a strong value proposition for hospitals and health systems *despite* its role in demand destruction: it allows for more stable practice economics, increased network referral capture, elevated physician and patient satisfaction, and stronger recruitment and retention prospects in primary care.

It's important to realize, however, that the medical home model also has a strong value proposition for hospitals and health systems *because of* its role in demand destruction. Though revenue impact is a sensitive issue for some providers, the "ambulatory-sensitive" DRGs most significantly impacted by the medical home fall into the bottom quartile—or in most cases, the bottom decile—of average contribution profit for a hospital or health system. The inpatient cases the medical home model keeps out of the hospital are exactly the types of cases hospitals should be seeking to manage outside the high-cost, acute care environment, especially when capacity is constrained and/or when the hospital is moving into a payment environment that rewards more accountable care."

Teresa Breen
Senior Consultant
The Advisory Board Company
Washington, DC

"Rather than posing as an option, I believe it should be restated as a credible, although admittedly idealistic, test of core values. Forward thinking hospitals and health systems recognize that they will be increasingly held accountable by public and private funders, regulators, and consumers for delivery of appropriate, timely, and efficient care. Business models, whether for-profit or not-for-profit, that depend on unplanned or avoidable use of capital intense services such as the hospital and ER and capitalize on missed upstream opportunities to improve patient outcomes will and should be intensely scrutinized. 21st century hospitals will need to increasingly align with, and ideally foster capabilities like, the medical home to be strategically relevant in their local health communities."

Paul Wallace, MD
Medical Director for Health and Productivity Management Programs
Senior Advisor, Avivia Health
The Permanente Federation, Kaiser Permanente
Oakland, CA

*T*hought Leader's *C*orner

"The goal of any integrated health care delivery system such as Sutter Health is to provide the highest quality, most appropriate, and affordable care we can to our patients. We do not want to burden American health care with unnecessary ER visits or hospitalizations for exacerbations of medical conditions that are better managed proactively through care models such as the patient-centered medical home (PCMH). In fact, optimally caring for these conditions through an outpatient PCMH frees up our ERs and hospital beds for the high-acuity conditions and surgeries that belong in hospitals. Sutter is aggressively looking to optimize the quality of care for our patients wherever and however possible."

William J. Black, MD, PhD
Division Head, Palo Alto Medical Foundation
Sutter Health
Redwood City, CA

INDUSTRY NEWS

AAFP

AAFP Patient-Centered Medical Home Checklist

The American Academy of Family Physicians has a new tool on its web site for all practices interested in becoming patient-centered medical homes. Each building block in the online graphic clicks through to a specific checklist and set of tools for the various medical home components. Practices can see sample job titles and descriptions, self-assessment survey tools, and resources from TransforMED and from Delta Exchange, an online social networking collaborative of practices engaged in the transformation process. See http://www.aafp.org.

TransforMED℠ TRANSFORMING MEDICAL PRACTICES

TransforMED Launches Small Practice Support

TransforMED, a wholly-owned subsidiary of the American Academy of Family Physicians, last month announced the availability of a "Small Practice Package" to help solo and small physician practices make the journey to becoming a patient-centered medical home. Practices begin by completing an online assessment in which baseline practice metrics are established and change readiness is assessed for both leadership and staff. Through web-based tools and a designated facilitator who provides virtual support, TransforMED assists the practice over a two-year period to implement the PCMH model More information is at www.transformed.com.

University of Michigan Health System

National Survey on "ePediatrics"

The CS Mott Children's Hospital National Poll on Children's Health revealed some interesting facts about parents' desires to be able to communicate electronically with their children's health care providers, compared with their actual ability to do so. Among the findings: 55% would like get their child's immunization record and 40% would like to schedule appointments either through email or the Internet, but only 9% can do either now; 55% would like to fill prescriptions online, but only 11% can do so now. For the complete results see http://www.med.umich.edu/mott/npch.

Blue Cross Blue Shield of Rhode Island

Rhode Island Blue Cross Blue Shield ACO Initiative

Rhode Island Blue Cross Blue Shield signed an historic contract with Rhode Island Primary Care Physicians Corp. to create a statewide accountable care organization with patient-centered medical homes as the primary care foundation. The four-year contract took effect April 1 and includes 75 medical practices and 162 physicians in the IPA. The plan will pay a monthly fee on top of per-visit fees for patients with complex conditions or serious risk factors, as well as pay for nurse managers to work in physician offices helping medically complex patients manage their conditions. Currently 65 physicians serve BCBSRI members in medical homes. By next year another 35 new physicians will have qualified, with the goal of the entire IPA in medical homes by 2014.

The Journal of Pediatrics

Pediatric Medical Home Cuts ED Visits

For those who missed the April 2010 *Medical Home News*, the results of the Pediatric Medical Home Project at UCLA, which saw a 55% reduction in emergency department visits, is published in the June issue of *The Journal of Pediatrics* (Volume 156, Issue 6, pp.1006-1010).

PRICEWATERHOUSECOOPERS

PwC Report – More Individualized Care

A new HealthCast survey report from the Health Research Institute at PriceWaterhouseCoopers cites six trends that will continue to move health care both in the US and globally toward more customized, individualized approaches. The six are incentive payments for outcomes, shifts in funding from sickness to wellness, broad regulatory reforms, patient communication that supports choice, EMRs and IT, and flexible workforce models in primary care. The report -- *The Customization of Diagnosis, Care and Cure* – also cited five "touchpoints" that health systems will use t engage individuals. These are coordinated care teams, fluent navigators, patient experience benchmarks, medical tourism (both for better cost and science), and wireless access. Visit www.pwc.com/us/en/healthcast/index.jhtml.

Catching Up With … Governor Jim Douglas (R-VT)

Governor Jim Douglas is in his fourth consecutive term, having been elected Governor in 2002 and re-elected in 2004, 2006, and 2008. He also currently serves as chair of the National Governors Association. His service to the State of Vermont spans 30 years, as member and later Majority Leader of the House of Representatives, Secretary of State, and Treasurer. He has received more votes than any other person in Vermont history. He talks about current challenges facing the States, health reform, the Vermont Blueprint, behavioral health and the patient-centered medical home, and himself.

The Honorable James H. Douglas, Governor of Vermont

- Governor of Vermont (2002-Present)
- Chair, National Governors Association (2009-Present), Vice Chair, 2008-2009
- State Treasurer, State of Vermont (1994-2002)
- Secretary of State, State of Vermont (1980-1992)
- Member, Assistant Majority Leader, and Majority Leader, House of Representatives, State of Vermont (1992-1979)
- Numerous civic and community service boards and positions, including Town Moderator for Middlebury for more than 20 years
- Recipient of the National Order of Quebec from the Government of Quebec, the first American politician so honored (2010)
- BA degree from Middlebury College, Middlebury, VT.

Medical Home News: *One of the distinguishing features and strengths of the Vermont Blueprint is the integration of behavioral health and primary care. Was this a State priority before the medical home model came into being?*
Governor Douglas: It has been a long-standing priority in Vermont for patients and families to have access to well-coordinated healthcare. Behavioral health, improved self-management, and helping patients and families achieve their goals and engage in healthy lifestyles should be integral parts of primary care. Medical Homes, supported by Community Health Teams, begin to make this possible by having care coordinators, social workers, and counselors readily available in the primary care setting. And our multi-insurer payment reforms make this a sustainable model.

Medical Home News: *Did the invitation to join Secretary Sebelius at the White House in September for the Advanced Primary Care announcement come as a surprise? And how big would Medicare participation in the Blueprint be?*
Governor Douglas: This was a very welcome announcement, and I was honored to be asked to join Secretary Sebelius and Nancy-Ann DeParle. I believe the invitation was recognition of Vermont's innovations and leadership in this area. Having Medicare involved is critical in order for Advanced Primary Care to be effective and sustainable. Payment reforms need to support high quality primary care for the general population, and Medicare is a major player. We need all insurers to move away from payment streams and financial incentives that promote episodic and reactive care. Primary care providers need adequate time and financial support to change the way their practices operate, and to incorporate the most effective approaches to well coordinated care. We have an aging population that accounts for a large proportion of most primary care practices. Medicare has to be part of this in order for reforms to be effective.

Medical Home News: *How risky was it for the President and Congress to make Medicaid expansion, even with short-term help, such a major part of health reform at a time when States are struggling mightily to balance their budgets?*
Governor Douglas: I believe the impact on many state budgets could be significant. In Vermont, we've chosen to expand Medicaid over time, and we now cover individuals under a variety of programs up to 300% FPL. Yet for a majority of states, Medicaid is still a program that covers low-income women, children, and individuals with disabilities. I do worry that health care reform that does not respect the fiscal realities of state governments could not only fail to improve the system, it could sap vital resources needed for areas like education and the environment. Unlike the federal government, states can't print money. We have to balance our books at the end of each fiscal year, and doing so certainly isn't getting any easier. The Fiscal Survey of States shows the combined remaining state budget gaps that must be filled for 2010 through 2012 equal $136 billion.

Medical Home News: *In neighboring New Hampshire, APRNs have full clinical privileges with no requirement for physician oversight, and there are now medical homes there run by nurse practitioners. Is there any thought to expanding the license of APRNs in Vermont as an additional way to ensure good primary care and address the shortage of primary care physicians?*
Governor Douglas: A special one-year primary care work force development committee was created this year to determine the additional capacity needed in the primary care delivery system. This will be especially important in helping Vermont achieve our health reform goals that place such a key emphasis on enhancing the primary care infrastructure. The committee's charge is to create a strategic plan for ensuring that the necessary workforce capacity is achieved in the primary care delivery system, and it will include representatives of the University of Vermont College of Nursing and Health Sciences, which trains APRN's in Vermont, as well as representatives of the Vermont Nurse Practitioners Association, the Physician Assistant Academy of Vermont, the College of Medicine, Medical Society, and others with health care work force expertise.

Medical Home News: *A question for you as NGA chair: with something like 20 States now challenging the constitutionality of the individual health insurance mandate under health reform, including attorneys general doing so against the wishes of their governor, is this kind of disruption affecting the National Governors Association policy and legislative agenda for health care?*
Governor Douglas: No. When governors assembled in Washington for our annual meeting, we had a robust discussion about the health care system and need for reform. And while the governors have their differences, I was amazed by how much we all agreed. We had a serious discussion about the problems in our current system and the vital need for actions to contain costs and improve system performance. You can watch the video at www.nga.org.

Medical Home News: *Finally, tell us something about yourself that few people would know.*
Governor Douglas: In a long career I have actually had the privilege of leading five separate national organizations – the Council on Licensure, Enforcement and Regulation, the National Association of Secretaries of State, the National Association of State Treasurers, the Council of State Governments, and currently the National Governors Association.