PATIENT CENTERED MEDICAL HOMES WITH THE OSTEOPATHIC PROFESSION'S SUPPORT: TRANSFORMATIONAL, EVOLUTIONARY, AND POSSIBLE

A CALL TO ACTION WHITE PAPER

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INTRODUCTION

Current healthcare challenges are calling for a bold new endeavor in our profession, a process that will remove some corporate institutional myths of what we can and cannot do. We must return to the home of healthcare, the doctor caring for and in relationship with their patient. It is not a surprise that physicians as artists are attracted to the word "home." Many other artists use "the home" as the basis of their art. Going home. Being home. Being where your heart is. These are all mental triggers for a grander entrance into creativity: safe, at peace, relaxed and protected so that the creative process can begin.

Osteopathic family physicians are called to educate, ignite, and inspire:

> Educate patients and physicians on the Patient Centered Medical Home (PCMH).
>
> Ignite PCMH discussion between physicians and physicians, between patients and patients and between physicians and patients.
>
> Inspire creative PCMH thinking by documenting physicians at work and in their own words.

WHY OSTEOPATHIC FAMILY PHYSICIANS?

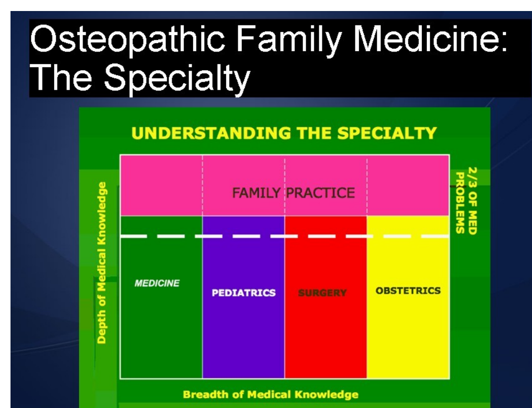
Our profession is the quintessential model of the medical home. We have been trained to listen and treat the whole person, not just their symptoms. We have been taught to focus on prevention and chronic disease management.

When patients talk to their physicians, they are not always looking for answers. They want someone to listen, to hear, and to understand. Our art includes the art of narrative medicine where the physician interprets a patient's story based on both their understanding of the patient's history (personal and physical) and upon their Osteopathic medicine knowledge base. The true art of medicine is assembling the information and making sense of each patient's story. Other healthcare models are not as competent in meeting the patient or the physician's needs.

Osteopathic medical schools produce a high percentage of family physicians. This niche affords Osteopathic medicine an important seat at the table in the resuscitation of family medicine and the healthcare system in general.[1] Just as Dr. Still pioneered Osteopathic medicine in 1874, today's Osteopathic physicians continue the tradition of bringing healthcare to the areas of greatest need:

- Approximately 65% of practicing Osteopathic physicians specialize in primary care areas, such as pediatrics, family practice, obstetrics and gynecology, and internal medicine.

- Many DOs fill a critical need for physicians by practicing in rural and other medically underserved communities.
- DOs are able to combine today's medical technology with their ears - to listen caringly to their patients, with their eyes - to see their patients as whole persons, and with their hands - to diagnose and treat injury and illness.[2]
- The PCMH model will help reengineer family medicine so that the emphasis is on relationships; the relationship is the cornerstone of the medical system, with the physician as the captain of the ship, not the insurance company, and not the government as the captain of the ship.
- As the graph below depicts, the silo of knowledge for Family Medicine is broad and touches all the other silos of care in the house of medicine. This fact makes the Family Physician one of the most efficient coordinators of Americas' healthcare.



Thomas N. Told, DO, FACOFP dist's 2006 ACOFP Many Faces of Family Practice PowerPoint

Dr. Ronnie Martin, 2008/2009 President of ACOFP, sees potential for changing the current medical thinking towards a patient-centered system in the new Obama administration:

> President Obama is calling for major reform of the healthcare system now, not later. We must work with the administration and Congress to ensure that the conversation is focused more on quality and healthy outcomes for our citizens, and not merely on cost. Providing more insurance in our current system will not improve quality outcomes or save money - study after study has proven that already. The system must be based on primary and preventive care to accomplish either. If we do the right things, we will save money and improve quality of life. If we do not, we will improve neither in the end. We have a chance not seen since Teddy Roosevelt and certainly not since the passage of the Medicare laws in the 1960's to change our healthcare system, to one that serves our patients and values health, not the system itself. We must be prepared to encourage and support actions that will improve the health of our patients and the role of primary care and Osteopathic physicians. We must not let it slip away by leaving the responsibility to others *(Leading the Osteopathic Way, February 23, 2009).*

COMPONENTS OF THE PERFECT STORM – LEGISLATIVE URGENCY, CONSUMER NEEDS, PHYSICIAN NEEDS, AND HEALTHCARE STATUS QUO MELTDOWN

Legislative Urgency

- Right now legislators, large employers, patient groups, and organized medicine are actively pursuing the PCMH model.[3]
- In June 2008, 108 bills were introduced in 26 state legislatures mentioning the words "medical home." [4]
- The American Recovery and Reinvestment Act of 2009 provides $59 billion in new healthcare funding including $2.5 billion for "health resources and services." In his address to the nation on February 24 2009, President Obama stated:

  > When it was days old, this Congress passed a law to provide and protect health insurance for eleven million American children whose parents work full-time. Our recovery plan will invest in electronic health records and new technology that will reduce errors, bring down costs, ensure privacy, and save lives. It makes the largest investment ever in preventive care, because that is one of the best ways to keep our people healthy and our costs under control.[5]

- Ongoing reports build evidence that PCMH intervention will lead to cost savings, better health outcomes, and higher patient satisfaction.[3]
- Pilot Programs:[6]
  - In May 2008, Six Pennsylvania insurers, including Independence Blue Cross and Aetna, said they would spend $13 million over three years to pay doctors in 32 primary care practices to help them set up medical homes.
  - Minnesota's governor in May 2008 signed a law that will use state and private funds to pay primary care doctors who create medical homes.
  - Nationwide, 27 of 30 Blue Cross/Blue Shield insurers are testing pilots of the model.
  - Employers such as IBM, Dow Chemical, and General Motors joined doctors, insurers and the AARP to advocate medical homes
  - A chorus of voices is gathering to make a revolution possible.

THE NEEDS OF CONSUMERS AND PHYSICIANS

For Consumers

There is a "quality chasm" in healthcare, and it is wide. Americans pay more, and our government invests more, yet there is no evidence that all the spending is yielding better quality or improving health outcome ROIs.[7] An increasing prevalence of chronic diseases

among the U.S. population is motivation alone for change. Studies on healthcare services to date reflect a lack of efficiency across the board. Uncoordinated care costs patients and healthcare providers dearly. Unnecessary tests and procedures add a great financial burden to patients and healthcare facilities.

A video on the Wisconsin Academy of Family Physicians' website presents the experiences of two different patients, one who has a medical home, and one who does not. The differences are dramatic and persuasive and exemplify how the PCMH can lower the cost of healthcare and offer a healthier outcome for all patients. View the video at http://wafp.org/VideoPCMH/index.html.

Medical homes are an excellent opportunity for physicians to provide a competent portal to healthcare that patients see to be positive and beneficial. The positive response from patients allows for positive 'word of mouth' advertising for the PCMH.

For Physicians

The results of an October 2008 survey of U.S. physicians about their profession paints a grim picture. The majority of current physicians would not recommend medicine as a career and the majority of allopathic medical students are choosing not to become primary care doctors. Efficiency in primary care in the U.S. is not rewarded and broad gaps exist in the difference between payments to primary care providers and those providing sub-specialty care. Medicare's physician payment methods are focused on chronic disease care, rather than patient education that helps divert the need for such care. Today's payment methods do not support patient education or coordinated care, but are instead offered for episodes of care or capitation.[8]

A survey of 161 attending physicians and 101 residents practicing at a large urban teaching hospital and 21 suburban primary care practices found that:[9,10,11,12]

- All respondents believed it was important to notify patients of abnormal results, yet 36% said they do not always do so.
- 72% said they do not notify patients of normal results.
- 77% said there was no reliable method for tracking whether patients with abnormal test results had received the recommended follow-up care.
- 97% did not know if their patients took their prescribed medication.

HEALTHCARE STATUS QUO MELTDOWN

Core Problem(s) with the Healthcare Status Quo

In a detailed interview with Dr. Stanford Owen, *(e-mail interview Owen, February 23, 2009)*, a family physician who has been in private practice for more than 25 years on the

Gulf Coast of Mississippi, explained that there are four major cost components to modern healthcare:

- Physicians
- Hospitals
- Laboratory and Imaging (x-ray) centers
- Pharmacy

Each operates more or less in a vacuum, but all are intimately connected through the physician. Only the physician can make the diagnosis, perform diagnostic tests, recommend a treatment, and plan the follow-up of treatment. Yet, the physician is the least expensive of any component. Lab, imaging, hospital, and pharmacy costs far outstrip the average physician charges in a given year.

Payment evolved to an insurance payment system based on the Medicare model that paid physicians and hospitals for specific services, levels of service, or tests they performed. The number and type of tests, procedures, treatments, and specialists have exploded in the last 40 years. Because demand for these high-tech services is greater than the ability to afford such services. Restraint and constraint has been regulated or legislated into the system. This has evolved into an unmanageable system that forces restraint of access by patients or constraint of physicians with threats of punishment for deviation from massive number of rules.

The current system rewards physicians for doing tests or procedures rather than cognitive (or “thinking”) time. Patients drive cost by demanding the latest and greatest treatment or test with opinions from multitudes of “specialists.” Patients want a specialist to see them for “body part” treatment: a dermatologist for a rash, an orthopedist for a sprain, a neurologist for a headache. In short, patients no longer trust a single practitioner. They not only demand more care, many demand the most tests, or opinions available. Each additional specialist demanded by the patient is then driven by reward from tests in her or her specialty. Patients frequently press the doctor and the insurance until all (patient, physician, and insurance) are exhausted. Insurance, physicians, and patients share equal blame. The damage can be extensive to patients in financial cost and physical harm.

Patients have been trained as consumers in every aspect of our society. They have been taught to consume the most expensive, because that is the best. i.e. a Mercedes is better than a Chevy.

Physicians are under intense, distracting pressure. Why? Imagine the physician listening intently to your history, symptoms, and physical findings while at the same time trying furiously to document in the chart all that you are discussing. Physicians are paid on how much they document in the chart, not how much real time or effort they spend with the patient. They are also under threat of civil and/or criminal penalties if the documentation does not support the level of billing. An Osteopathic physician cannot even do physical

manipulation when it is indicated as secondary to time constraints and reimbursement issues or even contractual issues (many insurance companies carve out manipulation as physical therapy that is contracted with either physical therapists or chiropractors.)

Simultaneously, the physician must consider whether the patient has insurance or the type of insurance since further testing or treatment may depend on the level of insurance coverage. The physician has to worry about which tests are covered, where the service is covered, which medications are allowed, if pre-approval is required, and which insurance computer is tracking the progress for each different insurance policy. If you are one of 55,000,000 without insurance, the physician has to figure out how to get the patient the needed care and is the one ultimately responsible for accessing that care. Either situation is time-consuming and stressful to both patient and physician.

Ultimately, the physician must balance cost of business versus the time needed to properly diagnose or treat the patient since the final distraction is that of malpractice. With all of these factors swirling in the physician's head during the patient interview, the physician still has to focus back on the patient to acquire the information for best treatment.

Besides the stress of patient care, financial stress on physicians results from insurance contracts that pay 30-60% on the dollar of what is charged, if they pay at all. Worse, many of the companies then fight each of those discounted charges. The financial burden of this constant battle is enormous, forcing most physicians out of private practice and into large groups or hospitals where they work for a salary while other bureaucrats fight these battles and further drive up costs *(e-mail interview Owen, February 23, 2009)*.

In addition, many organizations responsible for payment are constantly threatening to decrease payments to physicians (i.e. Medicare) and thus make fiscal planning impossible for doctors.

Dr. Donald Jablonski has been a primary care physician in Henderson and Transylvania counties of North Carolina for 10 years and has been practicing medicine since 1981. Dr. Jablonski describes how the relationship between a physician and a patient is always interrupted by the insurance carrier in the modern clinical practice: "My function is to select the best, most cost-efficient treatment for my patients and their medical condition. I want to make the decision based on my 27 years of experience, not based on an insurance company's policy *(Henderson Times-News, February 5, 2009: Opinions)*." Dr. Jablonski states that his impending retirement is due in part to the constant stress of dealing with insurance regulations that would compromise his medical decisions.

BUILD YOUR MEDICAL HOME ON A SOLID PRIMARY CARE FOUNDATION

The term 'medical home' spans across four decades and was first used by the American Academy of Pediatrics (AAP) in 1967. MassGeneral Hospital for Children defines a Medical Home as "primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective." Since its inception, the World Health Organization (1978) has embraced the term. The Institute of Medicine provided the tenets that established the framework for defining the concept of the Patient Centered Medical Home (PCMH) in 2007 through a consortium of several leading organizations including the American Osteopathic Association (AOA), the American Academy of Family Practice (AAFP), the American Academy of Pediatrics (AAP) and the American College of Physicians (ACP).[4] The consortium also promoted aspects of the Chronic Care model known to enhance cost effectiveness of patient care and improve the quality of care as a mechanism for improving primary care delivery.

In 2008, the Patient Centered Primary Care Collaborative (PCPCC) compiled a report that researched the ongoing efforts around the country to build evidence that PCMH leads to cost savings, better health outcomes, and higher patient satisfaction. The bottom line of their research is that care delivered by primary care physicians in a PCMH is consistently associated with:[3,13]

- Better outcomes
- Fewer preventable hospital admissions for patient with chronic disease
- Reduced mortality
- Lower utilization
- Improved patient compliance
- Lowered medical spending

PCMH CORE FEATURES

PCMH has several very attractive core features that appeal to both patients and physicians. Although seemingly simple, establishing the core features of the PCMH is a commitment to achieve in the current healthcare landscape in the United States.[6,7,14] This is why Osteopathic family physicians need to unite with each other, with their associations, and with their government leaders to modify the healthcare system status quo. PCMH core features include:

- **Quality and Safety -** Physicians engage in performance measures for continual improvement and accountability.
- **Personal Physician -** One physician oversees care provided by others throughout the process, promoting collaboration and teamwork.

- **Physician Directed Medical Practice -** The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole Person Orientation -** The whole person approach tackles issues dealing with mind and body and integrated care blends family and healthcare services to meet cultural and language needs.
- **Enhanced Access -** Enhanced access establishes improved communication between patients and healthcare delivery systems.
- **Payment Reform -** Payment reform practices designed to reduce waste and inefficiency and enhance patient-centered care and accountability are promoted.

POTENTIAL OPPORTUNITIES FOR PCMH:

Integration of PCMH Core Features

The core features of the PCMH model are a radical departure from conventional healthcare practices. Moving the focus to patient-centered treatments from process-based treatments requires physicians, medical centers, and insurance organizations to accept that new learning paradigms need to be followed.

- To transform the concepts of PCMH into reality, our mindsets as they exist today must change.
- Offering new payment models for services or episodes of care needs to be explored.
- Education for medical graduate students will need to focus more on patient-centered care, and funding via Medicare and Medicaid should lead this new trend in patient care.
- Ensuring accessible healthcare and insurance for all is essential to the success of any new trend in healthcare.
- Care reimbursement and incentives, evaluation of health benefits and continuous access to family-centered care must be a focus for all high-risk groups.
- Even with the advent of health information exchanges, advances in information technology and patient registries, patients are often left to deliver important aspects of their medical history from one healthcare system to another. The PCMH has the ability to bridge the gaps in the current system, which is behind other countries with fully functioning models. To achieve this goal, the PCMH should assist with tailored patient health decisions in addition to coordinating quality care and determining medical necessity.

Evidence PCMH Works

In the article entitled "Contribution of Primary Care to Health Systems and Health," Starfield *et al*.[15] details the role that primary care has played in influencing health promotion. Other publications describe the vital function that primary care plays in equal health distribution as well as prevention of illness and death.[16]

These positive findings center on the principle of looking at the patient as a whole and the ability to integrate physical and social needs. This principle is challenged when barriers to delivering coordinated care arise, such as in the case of depression. These barriers can include insufficient time allotted to spend with a patient, referrals needed to see another provider, and the reluctance of those diagnosed to be compliant due to negative connotations brought on by this diagnosis.

The medical home concept posits that primary care physician's direct and trusted relationship with patients, coupled with depth and breadth of clinical training across body systems, position them to assess an individual's health needs and to tailor a comprehensive approach to care across conditions, care settings, and providers.[17(p3)]

VISON – EDUCATE, IGNITE AND INSPIRE

EDUCATE - PCMH IMPLEMENTATION OF FOUR EDUCATION CORE COMPONENTS

PCMH Implementation Education Core Component One: How To Qualify A Physician Practice As A Medical Home

Many states are now starting to develop policies to incorporate the medical home model within their health programs. However, there is no standardization at the federal level for these policies and each state is responsible for implementing and developing its own policies and procedures. A table outlining state specific PCMH policies is provided in Addendum B. While policies are being developed at the state level, there is nation wide PCMH certification program provided by the National Committee for Quality Assurance (NCQA). The program has evolved since 2006 to incorporate technology advances in healthcare records

The NCQA Certification Program In The Patient-Centered Medical Home

Scoring in PPC-PCMH:

1. The number of overall points is the same but in some cases the distribution has changed:
   - The number of points increased for some elements
   - As indicated in Table 1, some standards and elements have been added and others have been deleted
2. One of the scoring options at the element level changed:
   - Increased from 20% – 25%
3. The number of factors increased in some elements but this did not change the scoring for those elements.

Table 1: PPC 2006 to PPC-PCMH Crosswalk[a]

PPC 2006 & PPC-PCMH Standards	PPC 2006 & PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 1: Access & Com- munication	PPC 1A: Access & Communication Processes	4	4 Must-Pass	Added factor: Identifying health insurance resources for patients without insurance			x		
	PPC 1B: Access and communication results	4	5 Must-Pass	None					
PPC 2: Patient Tracking & Registry Functions	PPC 2A: Basic system for managing patient data	2	2	Added factors: legal guardian, health insurance coverage and preferred method of communication			x		
	PPC 2B: Electronic System for clinical data	3	3	Added factor: Head circumference for patients ≤ 2 years			x	x	
	PPC 2C: Use of electronic clinical data	3	3						
	PPC 2D: Organizing clinical data	6	6 Must-Pass	Added factor: Screening tool for developmental testing and growth charts			x	x	
	PPC 2E: Identifying important conditions	4	4 Must-Pass	Added explanation for risk f actors associated with practice's demographics				x	
	PPC 2F: Use of system for population management	2	3	Added factor: Patients who might benefit from care management. Added explanation for pediatrics			x	x	
PPC 3: Care Management	PPC 3A: Guidelines for important conditions	3	3 Must-Pass	Added to element: ...evidence- based diagnosis and treatment guidelines		x			
	PPC 3B: Preventive service clinician reminders	4	4	Added examples for pediatric practices				x	
	PPC 3C: Practice organization	3	3	Expanded explanation of team of physicians and staff related to handling patient care responsibilities			x	x	

	PPC 3D: Care management of important conditions	5 Must-Pass	5	Changed factors from setting to writing individualized care plans and treatment goals			x	x	
	PPC 3E: Continuity of care	5	5	Added to element: ...patients transitioning to other care. Added factors: written transition plan and help identifying new PCP or specialist		x	x	x	
PPC 4: Patient Self-Management Support	PPC 4A: Documenting communication needs	2	2	None					
	PPC 4B: Self-management support	4	4 Must-Pass	Added factor: provides written care plan to patient/family. Added to explanation: written materials appropriate for patients. Added to examples: referrals to community resources			x	x	x
PPC 5: Electronic Prescribing	PPC 5A: Electronic prescription writing	3	3	None					
	Electronic prescribing interoperability	3	Deleted	Deleted					
	PPC 5C (B): Prescribing decision support—safety	3	3	None					
	PPC 5D (C): Prescribing decision support— efficiency	2	2	None					
PPC 6: Test Tracking	PPC 6A: Test tracking and follow-up	6	7 Must-Pass	Added factor: follow-up to get results on in-patient pediatric screening tests			x		
	PPC 6B: Electronic system for managing tests	6	6	None					

PPC 7: Referral Tracking	PPC 7A: Referral tracking	4	4 Must-Pass	Added to element: Specialist or consultant report. Added to explanation: clinical details to include in referral		x		x	
	PPC 7B: Referral decision support	3	Deleted	Deleted					
PPC 8: Performance Reporting and Improvement	PPC 8A: Measures of performance	3 Must-Pass	3 Must-Pass	Added to factor: examples for pediatric practices			x		
	PPC 8B: Patient experience data		3	New	x	x	x	x	x
	PPC 8D (8C): Setting goals and taking action	3	3	Added family involvement				x	
	PPC 8E (8D): Reporting standardized measures	2	2	None				x	
	PPC 8F (8E): Electronic reporting—external entities	1	1	None					
PPC 9: Advanced Electronic Com-munications	PPC 9A: Availability of interactive Web site		1	New	x	x	x	x	x
	PPC 9B: Electronic patient identification		2	New	x	x	x	x	x
	PPC 9C: Electronic care management support		1	New	x	x	x	x	x
PPC 9: Inter-operability	PPC 9A: Use of prescribed standardized codes	1	Deleted	Deleted					
	PPC 9B: Electronically receiving data	1	Deleted	Deleted					
	PPC 9C: Electronically transmitting data	1	Deleted	Deleted					
	PPC 9D: Using data for referral reports	1	Deleted	Deleted					

[a]Data from National Committee for Quality Assurance[18(pp7-10)]

Achieving PCMH Compliance Recognition through Disease Management Organization

The NCQA PPC-PCMH recognition program scoring process is very dependent on information technology (IT) resources in a physician office. Pending future modification of the PPC-PCMH program, this emphasis on IT may place it out of reach of the large number of smaller primary care practices that have not invested in electronic records. In contrast, disease management organizations offer primary care practices considerable IT-based resources, which the PPC-PCMH recognition program does not explicitly recognize. This analysis suggests that adoption of a typical disease management organization's IT process could theoretically fulfill more than half the points necessary to achieve PPC-PCMH recognition.

Table 2: NCQA Physician Practice Connections – Patient-Centered Medical Home Content and Scoring[a]

PPC-PCMH Content & Scoring			
Standard 1: Access & Communication	**Pts.**	**PPC 5: Electronic Prescribing**	**Pts.**
A. Has written standards for patient access and patient communication*	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication*	5	B. Has electronic prescription writer with safety checks	3
		C. Has electronic prescription writer with cost checks	2
TOTAL	**9**	**TOTAL**	**8**
Standard 2: Patient Tracking & Registry Functions	**Pts.**	**Standard 6: Test Tracking**	**Pts.**
A. Uses data system for basic patient information (mostly non-clinical data)	2	A. Tracks tests and identifies abnormal results systematically*	7
B. Has clinical data system with clinical data in searchable data fields	3	B. Uses electronic system to order and retrieve tests and flag duplicate tests	6
C. Uses the clinical data system	3		
D. Uses paper or electronic-based charting tools to organize clinical information*	6	**TOTAL**	**13**
		Standard 7: Referral Tracking	**Pts.**
E. Uses data to identify important diagnoses and conditions in practice*	4	A. Tracks referrals using paper-based or electronic system*	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3	**TOTAL**	**4**
		Standard 8: Performance Reporting & Improvement	**Pts.**
TOTAL	**21**		
Standard 3: Care Management	**Pts.**	A. Measures clinical and/or service performance by physician or across the practice*	3
A. Adopts and implements evidence-based guidelines for three conditions*	3	B. Survey of patients' care experience	3
B. Generates reminders about preventive services for clinicians	4	C. Reports performance across the practice or by physician*	3
C. Uses non-physician staff to manage patient care	3	D. Sets goals and takes action to improve performance	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5	E. Produces reports using standardized measures	2
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	5	**F.** Transmits reports with standardized measures electronically to external entities	1
TOTAL	**5**		

		TOTAL	15
Standard 4: Patient Self-Management Support	**Pts.**	**Standard 9: Advanced Electronic Communications**	**Pts.**
A. Assesses language preference and other communication barriers	2	A. Availability of interactive web site	1
B. Actively supports patient self-management*	4	B. Electronic patient identification	2
		C. Electronic care management support	1
TOTAL	**6**	**TOTAL**	**4**
[a]Data from Torda[19]			

*Must pass elements

PCMH IMPLEMENTATION EDUCATION CORE COMPONENT TWO: IMPLEMENTING A MEDICAL HOME

How Does A Solo Or Small Group Practice Start A Patient Centered Medical Home?

Changing your practice dynamics and infrastructure to conform to the Patient Centered Medical Home (PCMH) tenants is no easy task – and it should not be. The healthcare landscape needs to shift its core back to the patient being at the center, supported by a full complement of services offered by a personal physician.

If you are interested in starting a PCMH, consider the following initial steps:

- Assess your practice by asking a few key questions. How quickly can the members of your group (clinical and non-clinical) adapt and maintain change? Does your practice have a mission statement or clear goal that is familiar to each staff member? Are you able to provide the guidance and tone necessary to develop and lead a collaborative team that puts the needs of each patient first?
- Take an online assessment of your practice to see where it ranks in its ability to adhere to the PCMH concepts at *www.transformed.com.* You might be surprised at where your practice ranks in this pre-assessment quiz.
- Survey a sample of your patients to see what they like, do not like, or wish to be improved upon with regard to your practice. Implement those suggestions that can be changed easily. For example, if patients indicate that they would like to feel more welcomed by the front office staff, institute a program that allows patients to recognize staff who are friendly and helpful to them during the visit.
- Look at the quality of care that you provide. We all feel that we deliver good care to our patients but are our recommendations consistent with evidence-based guidelines? Are we diligent in our medication management and the education that we provide patients? Are there process improvement policies in place that consistently drive practice improvement efforts?
- Is there room in your practice to incorporate more technology? Have you instituted an electronic medical record system, e-prescribing, or e-visits? These

advances have all been shown to increase the efficiency and productivity of a practice.

If there were questions above that made you pause, perhaps it is time to look at ways to reshape your practice. Reforming your solo or small group practice to reflect the PCMH model does not have to be a daunting task. Set goals that are shared with staff who reflect a commitment from everyone in the office towards positive change that focuses on enriching and enhancing each patients experience with the practice.

The National Committee for Quality Assurance (NCQA) has set forth a process by which physician groups can be evaluated to see if they meet the criteria for being designated as a PCMH. These criteria focus on the quality of care given as well as the efficiency of how the care is accessed, delivered, and coordinated. The tools measures are a blueprint for practices' efforts to build medical home capabilities. To obtain the NCQA Survey Tool free of charge visit https://inetshop01.pub.ncqa.org/publications/product.asp?dept_id=2&pf_id=30002-150-08.

Recommendations From Prominent Physicians

There are specific things you can do setting up a PCMH that will help make the process smoother. The following recommendations on setting up a PCMH are from prominent physicians who have experience in moving to the PCMH model.

Sarah T. Corley, MD, FACP is the Chief Medical *Officer for NextGen Healthcare Information (e-mail interview, February 26, 2009)*:

- Implement EHRs
- Develop close relationships with specialists who help care for patients with chronic diseases-usually cardiologist, endocrinologists, and ophthalmologists so that they can work to share information about the patient for the measures of CAD, CHF, and diabetes.
- Develop a robust nursing team to help with patient education and follow up

Jose Guethon, MD, MBA is the President of Metcare of Florida, Inc. Metcare is running the first Patient-Centered Medical Home pilot available to Medicare patients in the U.S. *(e-mail interview, February 24, 2009):*

- The first step is to make an informed decision about whether to embark on the journey. In my opinion, the best resources are Transformed, an organization sponsored by the American Academy of Family Practice (*www.transformed.com*), and the Patient-Centered Primary Care Collaborative or PCPCC (*www.pcpcc.net*).
- Make sure you take time to discuss with physicians who have experience with a practice that is similar to theirs. For multi-site group practices, Metcare is glad to share their story and recommendations.

- Decide up front what metrics you will measure to compare outcomes.
- The PCMH is a team-approach to care. Make sure you share your vision with and educate your staff.

Jeff Bauer, Ph.D. is a health futurist and medical economist who has written extensively on the concept of a patient centered medical home *(e-mail interview, February 24, 2009):*

- The doctor should make contact with selected local employers and business coalitions to indicate his or her interest in helping them save money on employee healthcare through prevention and disease management.
- S/he should contact his or her professional association (e.g., American Academy of Family Practice, American College of physicians) to identify available resources and plans for setting up the medical home.
- Once the doctor is in the process of opening the PCMH, s/he should contact local media with appropriate information that could lead to coverage in the press and on TV; the medical home is one of the few good stories to be told in today's economy.

PCMH IMPLEMENTATION EDUCATION CORE COMPONENT THREE: THE ROLE OF TECHNOLOGY IN A PATIENT CENTERED MEDICAL HOME

The principles of the PCMH revolve around the relationship between a patient and a personal physician who coordinates a care model that is both comprehensive and efficient. The use of technology as a medium to provide enhanced, collaborative care is vital in the PCMH model.

When we first hear the word technology as it relates to medical practice we typically think of electronic medical records (EMRs), but we may not realize the full capability that these systems have.

Protect Personal Information

EMRs have proven to be effective ways to store a patient's personal medical information in one centrally protected location. Often protected with a required username and password to log-in, information on who is accessing a patient database can easily be tracked. This feature provides a higher degree of security compared to paper charts.

Increased "Face Time" with Patients

How often have you searched for a missing consultation report or have not been able to find the last progress note for a subsequent visit? EMRs can eliminate this frustration by providing a secure central location for all documentation, correspondence, and results. A quick scan of the EMR prior to the patient's visit will allow you to have better recall of any areas of focus.

Enhanced Documentation

Have you ever been asked to interpret what you have written in a chart or on a

prescription? EMR's decrease medical errors caused by illegible writing in charts, on claim forms and on prescriptions. They eliminate the need to dictate or write notes hours (sometimes days) after a patient has left the office, which often lends itself to leaving out some detail however small. A signature and credentialing stamp is also a built in feature, eliminating the possibility of not complying with regulatory standards.

Enhanced Synergy with Other Applications
Most electronic systems have the ability to interface with electronic prescribing programs and financial software. Physician groups can now calculate financial measurements that include return on investments via their EMR. Care management databases can also be integrated with EMR's as well as practice management billing solutions.

Enhanced Person to Person Synergy
Technology in a medical office setting comes bearing more gifts then just electronic records. Some practices have also instituted practice websites with patient portals to download information, virtual medical receptionists, online scheduling systems, and ways to administer patient surveys and feedback electronically. The key to establishing and maintaining a PCMH is to embrace technological advances that weave together different components of the model.

Technology also helps to facilitate person to person synergy by creating new avenues of communication and information transfer. Technology now exists for text messaging to be used via computer prompts to remind patients of appointments, to remind patients to take diagnostic tests, to remind patients to take medications, do their home blood sugar checks and stick to diets. By incorporating the ability of patient and doctor to communicate via e-mail and text messaging, documented communication can occur that could be used to bring other care providers into the immediate information loop between the patient and the primary physician.

Interview Responses From Prominent Physicians

The following are interview responses from prominent businesses about what marketing programs they have instituted to engage customers in the new technology.

Kim Labow, Vice President of Marketing, and Product Management of Medfusion

> Medfusion's powerful web-based solutions virtually transforms physician/patient communications using applications for pre-registration, appointment requests and reminders, outbound messaging, lab results delivery, prescription renewals, online bill payment, virtual office visits, and unique web sites. Medfusion is the preferred portal and website provider for the Medical Group Management Association (MGMA) and the American Academy of Family physicians (AAFP) and was ranked number one by KLAS for patient portals in the "Software Category Leader." For more information, visit www.medfusion.net *(e-mail interview, February 25, 2009).*

Kim Lawbow's definition on how the ideal PCMH will perform in terms of technology

To achieve the different levels of Patient-Centered Medical Home, a practice will need to adopt clinical, administrative, and patient-centered technology. One of the core principles of the PCMH is that "information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication." There are many areas where technologies such as patient-provider communications will help practices achieve PCMH recognition, including:

- Ability for patients and doctors to communicate via e-mail
- Secure online tools for appointment requests
- User-friendly personal health record (PHR) that enables patients to better manage their health and care
- E-mail reminders for appointments
- Health maintenance and diagnostic reminders for preventive care
- Access to patient information and education

We need to champion novel technology solutions to urgent healthcare problems and help advance the technical systems that support clinical care in real world health settings. This would include medical devices that can talk to each other to dramatically improve patient safety and HIPAA approved communication systems such as text messaging from nursing stations, labs, and doctor to doctor *(e-mail interview, February 23, 2009)*.

PCMH IMPLEMENTATION EDUCATION CORE COMPONENT FOUR: REIMBURSEMENT FOR THE PATIENT CENTERED MEDICAL HOME – HOW WILL MEDICAL HOMES CURRENTLY AND IN THE FUTURE BE REIMBURSED?

The proposed compensation for a PCMH is based on recognition that activities related to care coordination take time, have value, and should be reimbursed. This approach differs greatly from the traditional fee for service system that exists today that structures financial compensation on units of face-to-face time spent with a patient. Advocates for the PCMH are asking for reimbursement to be based on three categories that include:

- Traditional fee for service
- Non-face-to-face time spent coordinating patient care
- Group's performance with pay for performance or quality measures

The following steps should be implemented in order to receive future reimbursements as a PCMH:

- Develop a mission statement and practice goal that is shared by all clinical and non-clinical members of the staff
- Maintain written standards that reflect patient access and communication
- Utilize electronic medical records and data information systems to track clinical and non-clinical care delivery
- Generate patient appointment tickler systems and physician prompts for necessary tests, vaccinations or preventive services
- Incorporate evidence-based guidelines into clinical practice as well as open access systems and alternative hours
- Integrate care management plans to assess patient barriers and successes. Consider having regular team meetings to evaluate the overall needs of each patient
- Demonstrate coordination of care with inpatient and outpatient facilities, specialists and other care providers
- Address the needs of the patient by assessing language or cultural needs
- Promote patient empowerment and self-management by providing focused education
- Hold all members of the staff accountable for their role in the care delivered to each patient
- Track laboratory tests and demonstrate follow-through with those tests that are abnormal
- Show that referrals are being tracked either electronically or by paper to ensure care collaboration among providers
- Engage staff in a continuous process of quality improvement and self assessments
- Produce and transmit standard practice reports
- Encourage patient communication via e-mail or group discussion forums

The steps above may seem overwhelming, particularly if your practice is already struggling with trying to keep up with patient visits, prescription refills, and test results.

National Demonstration Project Results

The National Demonstration Project (NDP) was a 24 month project started in June 2006 by TransforMED to pilot PCMH facilities in 36 family medicine practices throughout the United States. The project concluded in June of 2008, although evaluation is still ongoing. The NDP has been instrumental in providing baseline data on the process of creating a PCMH practice:

- Creating a PCMH is more than simply the sum of implementing all the individual model components and is still seen as a heroic endeavor.
- The path to creating a PCMH requires particular attention to the clinical process, the relationships among all members of the practice, and the relationships

between the practice and large health community, and the motivation of key practice stakeholders.

- The Project has already verified that incorporation of PCMH standards can lead to long term results such as higher patient satisfaction, increased job satisfaction, and improvement in hours worked without a reduction in overall income.
- At the conclusion of the NDP facilitation component, many of the participating practices wished to maintain the relationship network to continue improving and validating measurements for the medical home. These practices are now continuing the collaboration as the Touchstone Group.

Seeking The Ideal Payment Environment For The PCMH

The costs in healthcare are often driven by consumer patient demand. People have been trained to have the newest and the most technology in everything that they purchase, from fashion to cars to computers to cell phones, and this attitude carries over into their healthcare expectations. However, this is only one-half of the equation. It is equally as important to get physicians, especially the younger physicians, to accept the idea that not every evaluation requires the most expensive tests that the patient's insurance will allow. This is a necessary paradigm shift required to change the burgeoning costs of healthcare.

Looking at the existing payment models within the healthcare system and analyzing their suitability for a PCMH practice, we have:

- **Salary -** problems with productivity
- **Fee for service -** problems with overuse
- **Capitation -** problems with under use
- **Pay for performance -** problems with ignoring the things not attached to payment

The solution then is to provide a new approach: A 'blended' payment model is the answer for primary care and the PCMH.

Interview Responses From Prominent Physicians Describing How Their PCMH Is Currently Being Reimbursed: What Is Working And Not Working

Sarah T. Corley, MD, FACP is Chief Medical Officer for NextGen Healthcare Information and her description for how their PCMH is currently being reimbursed, and what is working and not working in this arrangement:

> There is currently not much support for PCMH nationwide. Payers have expressed verbal support for the idea of the PCMH but have yet to put into place any widespread payment reforms to reimburse practices for that model of care. Until payers will pay appropriately for the time and resources a practice must adopt to meet the goals of the PCMH, we will not see widespread adoption *(e-mail interview, February 25, 2009)*.

Jose Guethon, MD, MBA is the President of Metcare of Florida, Inc. Metcare is running the first PCMH pilot available to Medicare patients in the U.S., and his recommendations for how to begin setting up a PCMH are:

> We are not currently getting higher reimbursements; we are making the move to PCMH because we believe it will improve patient care, adding value to the consumer. However, we practice in a fully-capitated or global-risk managed care environment, so better outcomes drive profitability. There is no doubt that additional staffing, systems, and processes add to the overhead. For us, it is an investment. The true Return on Investment (ROI) will be measured in the next 24 months. You should also consider the outcomes not related directly to revenue/expense (P&L) such as creating a better work environment and its impact on staff retention and recruitment *(e-mail interview, February 25, 2009).*

How Will The Ideal PCMH Perform?

- Disease control
- Condition management
- Illness prevention
- Quality of life experience:
  - Fully engaged in life
  - Having fun
  - Enjoying an authentic experience
  - Not living with restrictions or denial
  - Permit play and imagination
- Sustainability:
  - Preserve community
  - Preserve environment
  - Preserve economic and ecosystems values
- Incorporate faith. According to a February 23, 2009 *Time* magazine[20] article, prayer is the number one alternative medicine offered in the world and proven to increase life expectancy and decreases cost
- Inclusion of Osteopathic manipulative therapy
- Cover the uninsured
- Improve the quality and value equality of healthcare while decreasing spending
- Prevent disease and promote healthier lifestyles
- Strengthen public health's capacity to protect our health
- Address the social determinants of health, housing, education, transportation, the economy

- Expand services such as nutrition, exercise, faith, illness care, and peace-of-mind

Interview Responses From Prominent Physicians Defining How They Visualize The Ideal PCMH

Jeff Bauer, Ph.D.
Dr. Bauer is a nationally recognized health futurist and medical economist. He also served as a medical school professor and was health policy advisor to the governor of Colorado. He has published more than 150 articles, books, web pages, and videos on healthcare issues.

Dr. Bauer's definition of how he visualizes the ideal PCMH is that "a properly structured and well-managed PCMH will save money for the purchasers and dramatically increase the doctor's satisfaction with medical practice because it is the best use of the skills of a good primary care physician *(e-mail interview, February 24, 2009)*."

Joe Guethon, MD, MBA, President & COO, Metcare of Florida, Inc.
Dr. Guethon's definition of how he visualizes the ideal PCMH:

> We believe PCMH is the correct model of care so we expect a functional PCMH will result in better access and coordinated care, higher revenues, increased number of customers (patients), and improved clinical outcomes as indicated by adherence to nationally accepted guidelines for care, compliance with medical treatment, etc *(e-mail interview, February 23, 2009)*.

Kim Labow, Vice President of Marketing, and Product Management of Medfusion
Ms. Lebow's definition of how she visualizes the ideal PCMH:

> Patients will receive care coordinated by their primary care physician working with specialists to make sure that all recommended services are provided and patients receive appropriate education about their illnesses and are encouraged to make the lifestyle changes they need to improve their healthcare. Lab and diagnostic tests will be shared electronically as will any information about care provided at settings outside of the primary care office *(e-mail interview, February 24, 2009)*.

Terry McGeeney, CEO TransforMed
Mr. McGeeney's definition of how he visualizes the ideal PCMH:

> The United States has a payment mechanism that is working exactly as it was designed to work— rewarding volume and procedures. The problem is that there has been inadequate regard for quality or outcomes. It is tempting to equate more with better when it comes to healthcare. We have a system that pays more for Dr. "Highly Credentialed" even though "highly credentialed" means taking care of only one organ system or one disease. We have a private payment system that spends over 30% of its precious healthcare dollar on administration.

Not only that, but much of a medical practice's time and resources is also spent trying to combat and navigate that highly complicated system.

As reformers and representatives work through a review of our U.S. healthcare system, it will be easy, in the name of consensus, to put off meaningful solutions or to create a process where the self-serving stakeholders have too much input. While I have no doubt the political forces in play will be significant if not nearly overwhelming, our nation's needs are clear: America needs a lower cost, high quality, value-conscious healthcare system that is sustainably financed and available to all.

Fortunately, the path to meaningful change already exists. That path is the concept of the Patient-Centered Medical Home. Every patient without exception deserves, indeed should demand, a personal relationship with a primary care provider. That provider should be rewarded for preventing disease and promoting wellness when possible, while at the same time effectively and efficiently managing and coordinating care when needed. We must invest in health information technology, pay for prevention and support care coordination with the best interest of the patient in mind. The measure of success should be true improvements in outcomes, not volume, and procedures. Hospital and sub-specialty care should be paid for only when appropriate – and again – according to improved outcomes and based on need, not volume, and procedures. Branded medications should only be approved and paid for if they are appropriate and have a defined value in the care of an individual patient. We have a government healthcare system that works and provides relatively good care, called Medicare. It should be available to anyone who has no other option *(Report from the CEO, February 25, 2009).*

Karen Smith, M.D., FAAP

Dr. Smith's definition of how she visualizes the ideal PCMH:

A Patient Centered Medical Home is a team physician led approach to providing comprehensive medical care to the individual patient. Family physicians are well trained to promote and carry out this effort due to the nature of the residency training programs that prepares each family physician to function in a variety of healthcare environments allowing each patient to be cared for in a comprehensive manner. The patient designates the medical home setting which then provides life long acute and chronic care in an age dependent fashion. The care is delivered in a mode that utilizes technological innovation to insure efficiency, quality, and access. Patients know who the doctor is and the doctor knows the patients as people first. An effective medical home is one which decreases medical errors, allows patients to have communication access to the physician, promotes preventive as opposed to secondary intervention, decrease the disease morbidity and mortality of a community, promotes healthy life style behaviors, decrease duplicate testing, decreases the use of emergency room for non-emergency care, and depends upon the relationship of the patient and

physician to create a life long plan for the patients over all well-being *(e-mail interview, February 24, 2009)*.

Dreana Janssen, DO and family practitioner with Cigna Medical Group and Andrea Houfek, MD, who formally practiced as a pediatrician and now is medical director of primary care at Cigna Medical Group.

Dr. Smith's definition of how she visualizes the ideal medical practice:

> In the past, I worked in a practice with three other family practice doctors and also had a solo practice. I had to close the solo practice because of the huge volume of paperwork, phone calls, payroll, hiring, firing, QuickBooks, overhead, etc. It was overwhelming! In my current role as a family practice physician at Cigna Medical Group, I can focus on the patient. I also enjoy working with such a great team of professionals as well as having the opportunity to interact with all of the specialty departments. Additionally, patients love the convenience of having everything - including lab, X-ray, and pharmacy - under one roof *(e-mail interview, February 24, 2009)*.

Dr. Houfek's definition of how she visualizes the ideal medical practice:

> I wanted to join a group that encompasses a model of care for patients that includes more than just what I can do as a solo physician. Our group includes many team members (diabetes educators, anti-coagulation clinic pharmacists and nurses, home-based care program, and key specialty physicians that I can call on for referral or advice, care coordinators, transition of care nurses for patients in the hospital, on-site pharmacies, lab and x-ray, etc.).
>
> We are not a PCMH per say, but a multi-specialty medical group practice division owned by CIGNA Healthcare of Arizona. Our practice is very similar to a Patient-Centered Medical Home and we are in the early stages of obtaining that certification via NCQA, in that there are a myriad of services available to me and my patients that help ensure high quality, integrated, patient-centered care is delivered. The safety net this provides to my patients is a huge reason why I work with Cigna Medical Group.
>
> If I have a patient with diabetes, for example, I can refer them to our diabetes educators for a six-week program of classes that teach them about their disease and how to live with it. My patients who have completed these classes are much more likely to be compliant with the medical regimens that I recommend to them. Another example involves my patients who require anticoagulation therapy. I refer them to our anti-coag "clinic" and they receive phone calls at appropriate intervals to let them know when to come in for lab work (or, if homebound, our home-based care team can visit them). The pharmacists and registered nurses in the anti-coag clinic then call the patient with the lab results, assess the patient's diet and other factors, and use standing orders/protocols to adjust the dosage of their Coumadin medication. This way, my patients who require anticoagulation are very closely monitored and regulated, and I can rest assured that they are well cared for even when I am out of the office *(e-mail interview, February 24, 2009)*.

THE VISION: INSPIRE & IGNITE

Increase PCMH Knowledge by Igniting Discussion and Inspiring Creativity

Social media on the Internet are empowering, engaging, and educating consumers and providers in healthcare. This movement, labeled Health 2.0, is defined as the use of social software and its ability to promote collaboration between patients, their caregivers, medical professionals and other stakeholders in health. Doctors are meeting online to share collective wisdom about challenging cases and solutions that work to transform the concepts of PCMH into reality. These web-based services can involve chat, messaging, e-mail, video, file sharing and discussion groups.

A PCMH is an opportunity to revitalize discussion of health-care that is truly centered around the well being of the patient. The doctors are those who, because of their close contact with the patients, have the highest velocity of ideas and the highest density of talent and creative thought when it comes to patient care. It only makes sense that facilitating these same people to interface on the topic of patient care will be fruitful and thought provoking.

In today's networked world, the fastest growing and fastest communicating medium has become the social networking sites on the Internet such as Twitter. Building such a social networking site via ACOFP or AOA for the primary purpose of allowing many healthcare providers access to the same forum would provide a portal to this desired connectivity. Such unconstrained communication would allow the acceleration and creation of new aspects of the PCMH model or even help to develop new healthcare models.

A three-tier portal for doctors to meet in a secure, non-judgmental fashion needs to be developed:

- **Portal 1** - Doctors Considering a PCMH
- **Portal 2** - Doctors in the Process of Creating a PCMH
- **Portal 3** - Doctors Currently Operating a PCMH

This concept will take advantage of the phenomenon of "The Wisdom of Crowds" that has begun to change physicians' relationships with each other. By sharing successes, failures, ideas, and epiphanies and debating options together, all physicians gain knowledge that can ultimately improve their medical practice. *PatientsLikeMe.com* is an example of a collective wisdom web site. Another example is *Sermo.com*, an existing physician social networking site.

Sponsorship of social media sites can help bond doctors, bolster trust with the organizations, and ultimately drive the implementation of PCMH. PCMH collaborators need to approach *Sermo.com* to incorporate a PCMH category to their already existing categories of Unite, Lead, Monetize, Research, and Network. Physicians can access this

site to post successes, failures, ideas, and epiphanies and see what physicians from around the country are thinking in response to their postings. The postings, created by physician colleagues in more than 68 specialties, represent the frontlines of medicine. When you want to share an observation, simply create a posting.

A quick search of these physician focused forums already yields many creative ideas, showing true out-of-the-box thinking:

- Develop a Wii game like Wii Fit Coach that is connected to the Internet and sends exercise information to the doctor that can be auto filled into the online medical history.
- Insurance covering a percentage of the cost of a Wii for patients with a BMI >25.
- Insurance covering a percentage of cost of putting a WII in every nursing home.
- Text message prompts for medication, diet, exercise, follow up visits and to schedule diagnostic tests.

Neal Sofian, Director of Behavioral Interventions of *ResolutionHealth.com* wants patient/physician communication to be completely seamless – whether through in print, via phone coach or online. Sofian stresses that no single one of these approaches is a solution in itself and that ultimately, all of the messages should reside where the patient can see all of the interventions and data.

Stories of Change

Documenting physicians at work and in their own words will inspire creative thinking. *The DoctorsChannel.com* is a useful, timesaving tool that condenses the overwhelming amount of information doctors are forced to navigate each day in a creative, informative way by using videos.

The PCMH collaborative can approach *TheDoctorsChannel.com* to add a PCMH category, where You Tube style videos of PCMH practice doctors would be available of the physician's at their office telling in their own narrative how they are running a successful PCMH, or how they dealt with a certain issue in setting up a PCMH.

Tap into the power of *Twitter.com.* Design a twitter page where physicians can submit questions about PCMH (either as a physician considering PCMH, or as a physician implementing PCMH). The question would be twittered to a consortium of PCMH physicians who could then respond directly to the question asker. An example of this technology in action is viewable at *helpareporter.com.*

Vision for the Future

We have to look where the microscope cannot see and where the scalpel cannot cut. This is a relationship-based profession and we need to expand the existing relationships and establish bridges to new relationships, but how?

1. Use of technology: HIPPA compliant text messaging to communicate and to eliminate errors, facilitate patient reminders (diet, exercise, use of medication, schedule test and consults and medical home appointments).
2. Community outreach from the medical home to non-traditional partners (in public schools of nutritional and infectious disease education), homeless shelters, science fairs, community service clubs (i.e. Rotary).
3. Tax credits to give incentives for physicians to convert to EMR and medical home models and for indigent patient care.
4. Shape public policy in other categories – Agricultural policy is nutritional policy is public health policy (think corn syrup).
5. Customer relationship tracking via existing information technology. Providing ability to monitor and modify treatment based upon broad experiences (i.e. past experiences via Social Networking, i.e. patient experiences with specific blood pressure or diabetic medicines, infertility issues or with psycho social stresses) and doctor peer based social networking sites.
6. The ability to provide a la carte services (i.e. walk in) The following is an A La Carte services model currently being utilized by Dr. Stanford Owen, as explained in an e-mail interview on 2/23/2009. "$120/visit and fee for service a-la-carte for each service provided (vaccination, suture, etc) $380/year for all services including vaccinations, an Executive lab panel, EKG/stress testing, bone densitometry, most shots (steroid, antibiotic), sutures. I charge $300 for the spouse and $200 for children (over 4). Business employees have the same options For this payment, I provide 24/7 access to my beeper number, e-mail, and schedule phone consultations for established patients (avoiding costly time and travel expenses) for simple problems or treatment adjustments.

   Most patients opted for the $380 plan and many families have signed up. Small business owners are ecstatic with joy and relief they can offer something that helps their employee and helps their business by keeping patients well. Employees can access care without having to leave work since the requirement of face-to-face encounters required by insurance for payment no longer exists. Amazingly, most Medicare patients signed up and a significant number of Medicaid patients followed. Demographics are unaffected: waiters and fishermen to doctors and lawyers all have contracted.

   Payment is handled at the first visit of the year. The contract remains in place for one year from that date. Renewal may be performed automatically or by notification automated by the credit/check service. This service (1.6% of transaction) makes automatic deposits, automatic check verification, and prevents theft or accounting mistakes by staff. I can handle 2000 patients without burden. Physicians can do the math and compare it to current income/expenses.
7. The young physicians are adamant about more time with each patient encounter. This can only occur if physician income drops (a disincentive to go into primary care) or if the per patient encounter fee increases and incentive for more primary care, or if group patient encounters (i.e. D.M.) are paid for.

8. Open exposure of insurance company acctural risk profiles so that both doctors and patients have a clearer understanding of survivability based upon measured standards.
9. Expansion of 'narrative medicine' education in Osteopathic medical schools. (Understanding of the patient's story and the narration of that story)
10. On call primary care physicians as are used by radiologist (see Night Hawk at http://www.nighthawkrad.net/.) NightHawk Radiology Services, headquartered in Coeur d'Alene, Idaho, is leading the transformation of the practice of radiology by providing high quality, cost-effective services to radiology groups and hospitals throughout the United States. NightHawk provides the most complete suite of solutions, including professional services, business services, and its advanced, proprietary clinical workflow technology, all designed to increase efficiencies and improve the quality of patient care and the lives of physicians who provide it. NightHawk's team of U.S. board-certified, state-licensed, and hospital-privileged physicians located in the United States, Australia, and Switzerland, provides services 24 hours a day, seven days a week, for more than 750 radiology group customers and the 26% of all U.S. hospitals they serve.
11. Expansion of primary care specialists – i.e. hospitalist, house calls, SNFsts-within the medical home practice model.
12. Recognition of faith and impact on health and disease state. The practice of religion is the number one alternative medical care in the United States.
13. Providing a structure within the medical home doctor-patient encounters that focus on care and focuses on the patient's peace of mind via communication skills.
14. The oldest and the poorest patients will not participate in text messages, or e-mail technology, but their care has to be augmented. They require the most explanations, the most time. Encouragement of community classes for nutrition and other care.
15. Expand dialogue with medical students to hear their vision and incorporate it into these new models. They will, in their innocence, tell us what will make them happy to enter the field of family medicine. This will provide unexpected benefits.
16. This profession is a calling, an art. We are called to care for, comfort, and give peace of mind to our patients. This cannot be done without the gift of time. We need to expand our time with patients with a shrinking pool of primary care doctors and an increasing population and older country. The only viable way to do that is group classes for disease specific conditions led by doctors with doctors being able to bill for the group encounter (i.e. all new diabetics, all mild hypertension, etc).

SUMMARY

Osteopathic family physicians are not under any illusions as to the difficulties that lie ahead over the next 12 to 24 months. Instead of retreating to the trenches hoping for respite, it is time to educate, ignite, and inspire the development of the PCMH model.

The Osteopathic community needs to mount a successful PCMH education public relations campaign. The most difficult and elusive component of success revolves around creating interest in the PCMH model, with both patients and the media. PCMH already has a buzz with consumers, media, the legislature, and physicians. The table is set, and the integral components have agreed to sit down and discuss, brainstorm and experiment. Find the opportunity amid the adversity. The perfect storm is forming and the clock is ticking.

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ADDENDUM A

POTENTIAL PCMH BARRIERS AND SOLUTIONS:

Challenge: The best workforce poised to staff the PCMH is currently under siege.
Solution: Promote financial incentives and retain a robust and diverse primary care workforce in the United States. The compelling reason to enter into a network of care will be the primary care network.

Challenge: Specialists and hospitals determined to keep the status quo.
Solution: Develop connections and educate specialty care:

- PCMH is NOT a gatekeeper system
- Jointly develop/identify referral guidelines
- Emphasis on transitions in care & continuity
- Referral agreements
- Care transitions programs

Challenge: Innovative technology is cost prohibitive without adequate incentives.
Solution: The NCQA PPC-PCMH recognition program scoring process is very dependent on information technology (IT) resources in a physician office. Pending future modification of the PPC-PCMH program, this emphasis on IT may place it out of reach of the large number of smaller primary care practices that have not invested in electronic records. In contrast, disease management organizations offer primary care practices considerable IT-based resources, which the PPC-PCMH recognition program does not explicitly recognize. This analysis suggests that adoption of a typical disease management organization's IT process could theoretically fulfill more than half the points necessary to achieve PPC-PCMH recognition.[21(p1)]

Challenge: Unfriendly reimbursement policies
Solution: The Patient-Centered Primary Care Collaborative recommends a three-part payment methodology, Including:

A) A monthly care coordination payment for the physician's work that falls outside of a face-to face visit and for the health information technologies needed to achieve better outcomes,
B) A visit-based fee-for-service component that is recognized for services that are currently paid under the present fee-for-service payment system, and
C) A performance-based component that recognizes achievement of service, patient centeredness, quality and efficiency goals.[22]

Challenge: Congressional opinion is fragmented
Solution: Take it to the grassroots and garner public support like President Obama did during his presidency run and after by using technology to create a one-on-one conversation with millions of individuals on a personalized basis.

Challenge: Educating the next generation of doctors
Solution: Some doctors resist change and other doctors make change happen. Which of the two those that resist change or those that make change happen, which of the two will more than likely attract the next generation of physicians to join them in practice? It is not always "which doctor pays more" The younger generation is geared for change. They expect it. They want to be part of it. They do not want to wait 30 years to be chief of staff of a hospital. They want their ideas heard now.

The University of Kansas School of Medicine-Wichita Family Medicine Residency Program at Smoky Hill in Salina, Kansas, unveiled plans in early 2009 to adopt the Patient-Centered Medical Home Model of care in its family medicine training and education program. The transformation project is supported in part by a grant from the United Methodist Health Ministry Fund.

For over 25 years, the Smoky Hill Family Medicine Residency Program has produced dedicated, well-trained family physicians serving rural Kansas communities. Now it is becoming one of the first residency programs in the nation to offer family medicine residency training in a patient-centered medical home environment.

"Family physicians at all stages of their careers are learning new and better ways to care for their patients," said Rick Kellerman, M.D., professor and chair of the Department of Family and Community Medicine at the KU School of Medicine-Wichita. "The adoption of the medical home model at the residency level is particularly important, because the office practices physicians learn in residency – good or bad – tend to translate into their 'real life' practice upon graduation."[23]

Implementation of scholarships or educational loan forgiveness programs to encourage medical students to choose careers in primary care. This strategy would address the shortage of primary care physicians to staff medical homes.

Incorporate work-training programs such as utilized at Westminster Free Clinic where high school students volunteer in the clinic and are introduced to a potential life-long commitment to medicine. Helping train the next generation concept.

Challenge: Matching Patients to Medical Homes: Ensuring Patient and Physician Choice
Solution: Giving patients some choice about which patients they will form meaningful medical home relationship with rather than having this dictated by a payer will enhance physician buy in. Patient perspective – patients need to know which practice serves as their medical home so they know who to count on to coordinate and manage their overall care. They need to be educated on what PCMH will provide. Ideally, the PCMH will help patients decide when to see a specialist, select a specialist that will serve both the patient's clinical needs and coordinate with the medical home physician, and achieve smooth transitions after a hospital discharge.

Challenge: Educating the Public
Solution: Present the concept to the "The Doctors TV" show about hosting a series of PCMH targeted 1 hour shows that explains in detail the patient centered medical home, what it can offer to the patient, how they can find a patient centered medical home, or how they can request their doctor become a patient centered medical home.

Challenge: End of Life
Solution: 90% of individuals interviewed with consistency state they wish to die at home, yet 90% of all anticipated deaths occur in hospitals, mostly in futile care. Individuals should make up their own mind on these topics and governments should stay out. Yet, most people never get around to making up their mind on these topics and they leave it to family to make the choices when they are too out of it to make a decision. A simple piece of legislation stating that no one will be permitted to collect social security until they have filled out an advance directive that will be file at their family, their physician, and the social security office. Begin the process of personal reflection and personal responsibility and decision making regarding this costly and wasteful cultural practice of our current end of life model.

Challenge: Resolving the On Call Problem
Solution: A medical home pilot project at The Geisinger Health System, an integrated delivery system in northeast and central Pennsylvania, showed a 20 percent reduction in hospital admissions and 12 percent decrease in hospital readmissions at their Lewistown Hospital.

In a medical home, a patient could expect to obtain care from the physician practice on holidays, evenings, and weekends, without going to the emergency room.[24(p6)]

Challenge: Preserving economic systems
Solution: By implementing PCMH, medical costs will be rein in other choices of society such as education; infrastructure will come to the forefront instead of languishing for funding.

Challenge: Preserving ecosystems
Solution: Not permitting pharmaceuticals to re-enter the ground water in toxic quantities. PCMHs can develop an education video on how to dispose of prescription medicines correctly as has been done on this You Tube Video
http://www.whitehousedrugpolicy.gov/drugfact/disposal.mov

Challenge: Increased costs, decreasing quality
Solution: Recently, The Commonwealth Fund issued a report, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*,[25] that includes 15 options for slowing the growth in healthcare outlays while improving access and quality of care. One option estimated the savings accrued if all Medicare beneficiaries in traditional fee-for-service were required to enroll in a medical home for primary care. In recognition of the enhanced services (care management, care

coordination, patient education, and same-day access to appointments), physicians would receive a per member, per-month fee in addition to the regular fee-for-service payments. Under the policy option, the projected net cumulative savings to national health expenditures is $60 billion over five years and $193.5 billion over 10 years. Most of the savings were derived from a decrease in hospital and physician expenses because of higher quality and more efficient care delivered by medical homes

Challenge: Improving patient safety
Solution: Information technology can reduce the rate of errors in three ways: by preventing errors and adverse events, by facilitating a more rapid response after an adverse event has occurred, and by tracking and providing feedback about adverse events. Data now show that information technology can reduce the frequency of errors of different types and probably the frequency of associated adverse events. The main classes of strategies for preventing errors and adverse events include tools that can improve communication, make knowledge more readily accessible, require key pieces of information (such as the dose of a drug), assist with calculations, perform checks in real time, assist with monitoring, and provide decision support.

Challenge: Chronic care
Solution: A major reason for escalating costs is the growing prevalence of chronic conditions, which now affect every portion of the population, from children to the elderly. In fact, nine of 15 diagnoses for hospital admissions are directly related to chronic conditions.

A good starting point for reducing U.S. healthcare expenses overall is to implement a long-term strategy to reduce the costs associated with unmanaged chronic conditions. As RAND and Dartmouth researchers have revealed, the return on investment is potentially significant – enough to fund expansion of insurance (increase access) and reduce demand for specialty care and acute services (reduced costs). Unfortunately, incentives to arrest the progression of chronic disease do not exist in the current healthcare system. In fact, it rewards acute episodic care while proactive care, care management, active integrated inter-specialty management, and even some preventative care services are not reimbursed.[26]

Figure. 2[4] Unhealthy Lifestyles and Aging Demographics Drive Costs Up

EXHIBIT 3
Decomposition of Changes in Nominal Health Care Spending, Fifteen Most Costly Medical Conditions, 1987-2000

Condition	Total change in spending (millions of dollars)	Percent changes in spending attributes to		
		Increased cost per treated case	Rise in treated prevalence	Increased population
Heart disease	26,228.5	68.6	1.1	30.3
Pulmonary	24,792.0	37.5	41.9	20.6
conditions	24.503.3	21.1	59.2	19.7
Mental disorders	17.734.3	41.9	27.4	30.7
Cancer	15,385.8	59.8	18.9	21.3
Hypertension				
Trauma	14.596.6	169.1	-108.5	39.5
Cerebrovascular	11.078.9	20.8	60.3	18.9
disease	10,282.8	44.3	31.6	24.1
Arthtritis	9,626.8	23.6	49.8	26.6
Diabetes	9,486.4	21.7	52.6	25.8
Back problems				
Skin disorders	7,286.5	54.8	22.0	23.2
Pneumonia	7,203.8	9.38	-18.4	24.6
Infectious	6,191.6	95.2	-17.5	22.3
disease	5,029.1	28.0	43.4	28.6
Endocrine	3,231.4	8.8	55.8	35.4
Kidney				

Source: 1967 National Medical Expenditure Survey (NMES) and 2000 Medical Expenditures Panel Survey, Household Components (MEPS-HC)

Note: All changes were statistically significant at the .05 level except for changes in spending, kidney disease (at the .10 level): rise in treated prevalence, heart disease (not significant): and increased cost per treated case, endocrine and kidney disease (not significant). Medical conditions ranked by change in spending between 1987 and 2000.

With the right preventive care, people can cut their risk of a heart attack by up to 80%, cardiologists estimate. "We have made major improvements in prevention...but it's difficult. It takes frequent visits, a close relationship between a physician and a patient and a very committed patient," says Dr. Gregg W. Stone, Director Cardiovascular Research at Columbia University.

ADDENDUM B

SIDE BY SIDE SUMMARY OF STATE MEDICAL HOME PROGRAMS

Side-by-Side Summary of State Medical Home Programs

The "Patient-Centered Medical Home" – a model of practice that emphasizes readily accessible, comprehensive, coordinated care – is rapidly gaining traction as a way to reform health care. Many states have begun work to implement "medical home" models in their health programs. This chart describes and compares these state efforts, including the population covered, provider requirements, payment policies, performance measurement and public reporting, the status of the efforts, and additional relevant notes.

Please note that this chart is not exhaustive, and currently only includes public and public/private initiatives. While there are many private sector efforts underway, these efforts are not yet part of this document. We will continue to update this chart, but encourage you to contact us with any additions or comments that could make this chart more useful for the group. Please send additions to Lee Partridge, Senior Health Policy Advisor, at lpartridge@nationalpartnership.org.

Side-by-Side Summary of State Medical Home Programs

Last updated 9/26/08

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
Alabama "Patient 1st" www.medicaid.alabama.us/programs/patient1st/index_patientlst.aspx?tab=4	All Medicaid beneficiaries except disabled and elderly	Providers must agree to act as primary care giver for patient. To earn "enhanced management fees," they must complete 3 training modules on health literacy, medical home, and Medicaid. Includes "In-Home Monitoring," a complementary program allowing Patient 1st enrollees with certain chronic conditions such as diabetes and hypertension to monitor their conditions at home by transmitting readings into a centralized database.	Multi-component case management fee, maximum of $2.60 PMPM. Elements of fee include use of health information technology, Providers also paid regular Medicaid fee for specific medical service given to patient Providers also share in savings realized by state from program.	Certain measures required. State issues provider report card.	Primary care case management program, in place since 2004.	Has very consumer oriented patient handbook with clear statement of rights, including access to family planning, and responsibilities
Colorado	Children enrolled in state Medicaid and Child Health Insurance programs	Legislative definition: "A practice that verifiably ensured continuous, accessible, and comprehensive access to and coordination of community based medical care, mental health care, oral health care, and related services for a child." Responsible for health maintenance and preventive care, anticipatory guidance, acute and chronic care, coordination of meds, specialists, and therapies, provider participation in hospital care, and 24 hour telephone care. More detailed standards require:	Pilot program will pay providers higher fee for comprehensive well child visits Additional payment to providers meeting medical home standards being considered	Will be required	Law (SB 07-130) enacted 2007. Implementation ongoing. State currently offering providers some assistance with care coordination and case management. Pilot program underway	State providing website for consumers to see provider credential and record of any complaints.

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State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
		- same day appointments if needed - provider and staff encourage family participation in health care decision making - medical record sharing with other providers if family authorizes - practice has a continuous quality improvement plan			(2008) with 24 providers and 1000 children	
Illinois Health Connect Web address: www.illinoishealthconnect.com	All Medicaid beneficiaries except those In HMO	Provider signs addendum to standard Medicaid physician participation agreement and promises to: - serve as patient's primary care provider -have hospital privileges or arrangements for admission -makes referrals to specialists -24/7 coverage -maintain office hours of at least 24 hrs/week (solo practices) or 32 hours/wk (group practices) -follow recognized preventive care guidelines -manage chronic disease Enrollees will be assigned a PCP if they do not choose one. Complementary disease management program available for chronically ill	$2 PMPM per child, $3 for parent, $4 for elderly or disabled Plus regular FFS fees Bonus for meeting or exceeding national 50th HEDIS percentile in: -immunization -dev. Screen -asthma mgt. -HbAIC -mammograms -well child	Provider profiling, not publicly reported, using 20 HEDIS and HEDIS-like measures, viz: Child imm, lead testing, asthma/diabetes care, well child and adolescent well care, prenatal frequency/timeliness, depression, cervical cancer screen, adult access to preventive care, rate of ER visits and ambulatory	Primary care case management program, began in 2007.	State provides special secure web portal to support PCP and grant access to patient roster. Beginning 5/2008 will also give patient's Medicaid claim history and 7 years of immunization data Beneficiaries under 21 may obtain preventive

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
		beneficiaries, currently targeting children with asthma and disabled adults		care sensitive hospital visits Calculates statewide benchmarks		health care from approved local health department, school-based clinics, and women's health care providers without referral from PCP.
Iowa	All state residents	Leads team of individuals at the practice level who collectively take responsibility for ongoing health care of patients. Provides or arranges for care by other professionals; care coordinated with community. Participates in NCQA voluntary recognition process or similar system to demonstrate practice has capacity to provide patient-centered services consistent with medical home model. Primary care provider can be: - MD who is family practitioner, GP, pediatrician, internist, OB-gyn - Advanced nurse practitioner - Physician assistant - Chiropractor	Reimbursement to be studied by state depts.. and recommended to insurers and state program administrators.. Assumes care management fee add on to FFS. Allows gain sharing, quality incentives. Recognizes value of IT.	Voluntary engagement in performance measurement and improvement. Measures to be specified by dept. For children, suggest immunization, ER use, well child and oral health utilization rates.	Section of an omnibus health reform bill (HF 2539) which became law May 2008	Legislation envisions statewide medical home system that offers care coordination, data collection and analysis, other assistance and monitors quality Medical home system would support both public and private

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State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
						programs, although implementation would begin w/ Medicaid program.
Massachusetts	Medicaid beneficiaries who enroll in planned pilot project	Practice must provide care using a medical home model that coordinates care across health care system and the patient's community. Detailed standards to be developed by state agency.	To be developed by state Medicaid agency. Payment should reward quality and improved patient outcomes.	Annual project evaluation, to be submitted to legislature, should include cost savings, health care screen rates, outcomes and hospitalization rates for patients with chronic illnesses.	Requirement included in omnibus health care quality improvement law (Senate 2863) enacted August 2008. Implementation turns on availability of funds and federal approval of payment structure.	New law also creates state quality and cost council which would determine what performance measures and cost information all providers would be required to submit to the state. Data would be reported on consumer web site.
Minnesota	Medicaid, SCHIP and state funded program for uninsured	All health care homes must: - Offer patient ongoing long term relationship with clinician, including advanced practice nurses and PAs - Provide care coordination	Per person pmts for care coordination, adjusted for patient care complexity. Providers might also quality for separate, add'l	Measures of quality, resource use, cost of care, and patient experience will be required;	New law, May 2008. Medical home standards and new payment system to be	Care coordination fees would be funded from savings in other

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
		- Enhance patient/family participation in decision making - . - Ensure use of HIT - Must participate in health care home collaborative re QI More detailed standards under development (2008-09)	quality incentive payments	which ones to be specified by state executive branch agencies.	developed by state DHS and DH. .	segments of medical programs, including HMO capitation fees if necessary
North Carolina *Community Care of North Carolina*	All Medicaid beneficiaries except elderly and disabled	Practice that agrees to participate in state's primary care patient coordination system (Carolina Access) and provide, direct, and coordinate the health care and utilization of health care services of practice enrollees. All necessary medical services must be provided directly or authorized and arranged through the practice. Practice is supported by regional CCNC entity which assists in care management, identifies resources, collects performance data, and provides feedback to practice.	PMPM fee paid in addition to regular FFS payments. Currently $2.50 CNCN networks also receive PMPM fee for each beneficiary.	Measures .	In place since.1998; statewide beginning 2002	Piloting expansion to disabled and elderly populations
Oklahoma Health Management program	Selected Medicaid enrollees w/ chronic conditions	Direct care management support (RNs) for identified Medicaid beneficiaries with high risk chronic conditions, plus assistance to providers in practice redesign to improve quality and efficiency.	No additional payment to providers Nurses hired by state.		Began in January 2008	

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
Oregon	Beneficiaries of public programs but available to others	Program should incorporate a health benefit model that promotes primary care medical home. Draft report (9/08) of Oregon Health Fund Board recommends Medicaid and SCHIP recipients be enrolled in an "integrated health home" (IHH) which reflect the patient-centered medical home model of team-based care, care coordination, and stress wellness, prevention and disease management.	Board recommends diverse IHH payment strategies be tested, including mix of fees for direct services and risk-adjusted bundled payment for care integration. Payment should also be tied to quality of performance.	Board recommends establishing comprehensive structure for collecting data on quality, cost, and outcomes from all providers and making publicly available.	Health Oregon Act of 2007 required Oregon Health Fund Board to develop comprehensive health reform plan for Oregon with specific action steps and timelines. Final Board report due 11/08.	Board report envisions IHH model adoption by other publicly funded program, including employee benefits, and private insurers
Pennsylvania Chronic Care Initiative	All beneficiaries enrolled in practices participating in regional medical home pilots.	Patient-centered medical home practice redesign initiative focusing on patients with chronic conditions. Initial focus: diabetics and pediatric asthma. Model based on the four professional society Joint Principles for Medical Home. .	Practices will receive increased reimbursement for attaining PCC-PCMH recognition, and also P4P. Funding supplied by participating insurers, including state Medicaid program.	Required.	First pilot located in SE Pennsylvania region in May 2008. Plan is to replicate in other regions of state.	Initiative lead by Governor's Office of Health Care Reform Practice redesign work being funded by foundation grant
Rhode Island *Connect Care Choice*	Adults enrolled in Medicaid program but not also eligible for	Primary care practices who agree to help coordinate care	Multi-component PMPM based on enhanced services offered Special additional PMPM for case managers for		In operation in some parts of state since 2007	

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
	Medicare and not enrolled in a Medicaid HMO		identified high risk patients Both payments in addition to regular FFS reimbursement			
Vermont Blueprint for Health http://healthvermont.gov	Patients with chronic conditions enrolled in public programs; private providers encouraged to participate.	Primary care provider (board certified, if applicable) who provides ongoing support, oversight and guidance to implement an integrated patient care plan, uses HIT and clinical decision support tools, and encourages patient self-management. Providers supported by community-based care coordination teams (CCTs) to assist with care coordination and patient education, including workshops to enhance patient self-management abilities.	Participating providers to be paid care management fees plus incentive payments for demonstrated compliance with established clinical protocols. Recommended fee structure under development.	Data analysis and reporting structure to evaluate pilots under development	Implementation of two pilots underway in 2008	Vermont has also launched Healthier Living Workshops across state to help residents with chronic illness learn techniques for managing their condition and working with providers in partnership.
Washington *Chronic Care Management Program*	Medicaid beneficiaries Identified as high-risk and not enrolled in HMO	State contracts with King County Care Partners, a provider network in King County to provide medical home; network determines provider participation State also contracts with AmeriChoice to provide care management services for clients outside KingCounty and help client find medical home	Fee structure negotiated with state under contract		Program started 2/07	
Washington	Children enrolled in	Practice where patient receives medically appropriate medical, dental	Various methods under discussion; likely to	Measures identified that will	Multistakeholder workgroup	

State/ program	Population covered	Provider requirements	Payment policies	Performance measurement/ Public reporting	Status	Special notes
www.medicalhome.org	public programs	and behavioral services and community support services, using team approach. Qualifying primary care practices must be willing to adopt medical home models as defined by the dept. of social and health services in its nov 2007 report to the legislature.	include specific incentives tied to quality improvement	reflect impact of medical home, such as childhood immunization rates, well-child visits	mandated by Child Health Act of 2007; 2009?	