



Creating Ideal Primary Care

By Joseph E. Scherger, MD, MPH

Hospitals and health systems have been setting up “Centers of Excellence” for many years. Cardiovascular disease, cancer, orthopedics, and neuroscience are common targets for idealizing care. Why not primary care? That may sound far-fetched with the current state of primary care practice and its hurried office visits, crowded waiting rooms, and frustrated patients, providers and staff. But creating ideal primary care is just what I was asked to do at Eisenhower Medical Center in the Coachella Valley (Palm Springs area) of California.

Another way to describe ideal primary care is to say that it meets the following criteria:

- Patients receive all the time they need and want for care with great service
- Patients receive the best care
- Physicians and staff enjoy their work and sustain high level professional satisfaction
- Medical errors are minimized
- Physicians are supported by a team and care for the right number of patients

This article describes two models of idealizing primary care. The first is an organized team model capable of care for a large population per physician. The second is a relationship-centered model focusing on a limited panel of patients per physician. These models are not mutually exclusive, and any given health system or practice may want to have elements of both.

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First Oncology Practice in the Nation Earns ‘Medical Home’ Recognition

By John D. Sprandio, MD

Consultants in Medical Oncology & Hematology, PC, a practice that provides care across three health systems in southeastern Pennsylvania, recently became the first oncology practice in the nation to earn Level III recognition from the National Committee for Quality Assurance (NCQA) under its Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH™) Program. The practice was recognized for using information systems to measure practice-wide clinical quality parameters and improvement in clinical outcomes at the point of care. Until recently, only primary care practices have earned this recognition.

The PPC®-PCMH™ program identifies practices that promote partnerships between individual patients and their personal physicians, instead of treating patient care as the sum of several episodic office visits. Each patient’s care is tended to by a physician-led care team, which provides for all the patient’s cancer care needs and coordinates treatments across the complex health care system. Medical Home practice related physicians provide superior, patient-centered care by providing open scheduling, expanded hours, appropriate use of proven health information systems, and assumption of an enhanced level of care coordination and communication with all treating physicians.

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In the organized team model, the physician focuses on the sicker or more complex patients requiring the extensive medical training of a specialist in primary care. Routine preventive care and treatment of common acute and chronic conditions are handled by a nurse practitioner or physician assistant. The care team includes other resource providers such as a counselor, nutritionist, pharmacist, diabetes educator, and fitness expert such as a physical therapist. Each of these providers is "right sized" to match the population being served, and everyone works to the limit of their license. A care coordinator, such as a nurse, makes sure that all patients are receiving the care they want and need. A shared information system allows for strategic proactive care and evaluation of patient satisfaction and outcomes. Depending on the size of the population being served, team members may be located together or close by. The organized team model fits an organization caring for a large population with limited resources, such as a community clinic or a staff or group model HMO such as Kaiser Permanente. As conceived by Tom Bodenheimer, a single physician may be responsible for as many as 4000 patients in this model (1).

In the relationship-centered model, all patients have a personalized connection with their chosen primary care physician. This physician knows all the patients well and focuses on optimizing their health. A new platform of online communication and care makes the physician continuously available to the patient. Most clinical communications go directly to the physician and may be triaged to an activated medical assistant or other team member. Given the smaller panel size, such as 1000 patients or less depending on the number of seniors, the practice team is small and may include just an assistant who is trained by the physician as a care coordinator. Other resource providers are readily available in a "neighborhood" of care provided by an integrated delivery system. A shared information system again allows for strategic proactive care and evaluation of patient satisfaction and outcomes.

The relationship-centered model of care resembles the service of concierge medicine, although most concierge practices simply provide cell phone access with the physician and do not have advanced information systems. Gordon Moore of Rochester, NY started the "ideal micropractice" model in 2002, and this has been refined by him and many "member" practices into the Ideal Medical Practice model (2). Charles Kilo and colleagues started an idealized primary care practice that has grown to two offices and nine physicians in Portland, OR called Greenfield Health (3). Eisenhower Primary Care 365 is modeled after Greenfield Health but had to modify the structure since more than 50% of the practice is composed of seniors (4).

It is not clear if the primary care physician's workday changes in the organized team model of care. One would hope that by focusing on the more complex patients, the physician would have more time with patients and see fewer each day. The busy office schedule with many brief visits has been described as running on a "hamster wheel" and is a major reason for dissatisfaction among primary care physicians (5). In the relationship-centered model, the smaller panel size allows the physician to spend more time with patients and have fewer visits daily, as low as 8-12 patient visits per day (2,6). Online and telephone communication with patients, and meeting with team members to discuss care coordination, become an important part of the physician's workday in ideal models of primary care.

The financial viability of any ideal model of primary care requires payment reform. There must be reimbursement to support the care coordination and communication with patients outside of visits. Prepaid models of care support this when the overall expenses are reduced through efficiency and a reduction of office visits. In the more dominant fee-for-service model based on office visits, a care coordination or "medical home" payment is required to support the work done outside of visits. Pay for performance revenue would then reward any ideal model of practice for improved outcomes.

Primary care is the foundation of any rational health care system. Quality primary care adds tremendous value to the overall health care enterprise, reducing costs and enhancing quality population outcomes. As specialty care in the U.S. has enjoyed a long period of idealized development, it is high time to optimize primary care practice. Doing so might save U.S. health care from a financial implosion as millions more people have access to health insurance in the coming years as a result of health reform.

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Thought Leader's Corner

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

Q. "What conditions and criteria would need to be addressed in order for a specialty practice to be considered a patient-centered medical home?"

"Any practice that has continuity of patient care should use the principles of the medical home and become a medical home practice. For example, a rheumatologist should be a medical home for patients with lupus and other major rheumatologic disease, a neurologist should be a medical home for patients with seizure disorders, movement disorders and multiple sclerosis. An oncologist practice should be a medical home for any patient with a malignancy requiring ongoing treatment. The list goes on, and this is complimentary to the primary care medical home. I would even suggest that an orthopedic practice should be a medical home to a patient from the first visit that determines the need for a joint replacement to the end of rehabilitation. With proactive care coordination and continuous access to communication, care would improve greatly."



Joseph E. Scherger, MD, MPH
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"The concept of 'patient-centered' implicitly implies 'population-centered' because otherwise patients who have greater resources available to them will command more patient-centered care and thus create a very inequitable system of health services. Specialist physicians cannot be medical homes because they cannot provide comprehensive care to populations (although they might be able to provide it to some individual patients); comprehensive care is part of every definition of the medical home."



Barbara Starfield, MD, MPH
University Distinguished Professor, The Johns Hopkins University
Director, Johns Hopkins Primary Care Policy Center
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"There will be fairly frequent patient-centered reasons for a specialist practice in cardiology to serve as the medical home for a substantial number of heart failure, congenital heart disease, arrhythmia, CAD, and other patients with serious or unstable cardiac disease. Gerontological cardiologists in particular will often be logical sites for a cardiovascular medical home. CV medical homes will need to meet all the criteria that a primary care medical home would address. And, such specialty medical home care settings will need to be coordinated with primary care in the same way primary care medical homes will need to be linked in careful coordination with specialty practices to provide the highest quality of patient-centered care."



Jack Lewin, MD, FACC
CEO
American College of Cardiology
Washington, DC

"There may be situations where the specialty/subspecialty practice may be the medical home for a subgroup of their patients. The specialty/subspecialty practice would be expected to meet the requirements of an approved third-party PCMH recognition process (for example the NCQA PPC-PCMH recognition), and affirm the willingness to provide care consistent with the "Joint Principles," including the delivery of first contact, whole person, comprehensive care. This situation is best represented by a specialty/subspecialty practice that is seeing a patient frequently over a relatively long period of time for the treatment of a complex condition that affects multiple aspects of his or her physical and general functioning. Representative examples include an infectious disease practice caring for a late-stage HIV positive patient or a nephrology practice caring for a dialysis patient with End Stage Renal Disease (ESRD)."



Fred Ralston, Jr., MD, FACP
Fayetteville Medical Associates
President, American College of Physicians
Fayetteville, TN

Thought Leader's Corner

"It would be appropriate if: 1) they met the criteria that are established by CMS and/or others, 2) they met special criteria that might be developed for a "specialist patient-centered medical home" because they provide nearly all of the care for selected patients and take responsibility for coordinating all of the patient's care for a given illness - for example End-Stage Renal Dialysis patients - One might imagine DaVita, for example, serving this role in selected markets. But, overall, I believe the number of specialty practices that would qualify or even desire to be a patient-centered medical home will be very small. Certainly less than 5%. The more important question is the role that specialists will need to play in regard to primary care oriented patient-centered medical homes as a part of Accountable Care Organizations."



Steve Shortell, PhD
Dean, School of Public Health
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Berkeley, CA

"Although the concept of providing a medical home is attractive, the structure of subspecialty care generally puts that goal out of reach. The concept of the medical home requires a comprehensive approach to all the needs of a patient, not just those in a specific specialty area. The physician must take into account the physical and psychological nature of health and disease in the context of family and community. Most subspecialists have chosen to focus their attention and their daily work on a single organ or set of disease conditions. There may be a rare instance when the patient has a single complex disease without other problems, such as HIV/AIDS. However, most patients do best with a generalist approach supplemented with appropriate subspecialty care.

Becoming a patient-centered medical home for an entire patient panel demands expansion of staffing to meet clinical and care coordination functions, greater investment in health information and communication technology, and expansion of expertise in the comprehensive, whole-person patient care throughout the life span, across all care environments from outpatient to inpatient to rehabilitation to end-of-life services. Adding the services required to become a certified medical home for all patients is probably unrealistic for most subspecialists, who already have considerable demand for their highly focused expertise."



Lori J. Heim, MD, FAAFP
President, American Academy of Family Physicians
Family Physician Hospitalist, Scotland Memorial Hospital
Laurinburg, NC

"Six criteria need to be met: (1) build and maintain the infrastructure necessary to support the disease management and care coordination responsibilities associated with the care delivered for the chronic condition associated with the specialty; (2) maintain a culture that assumes ownership of all disease specific related needs in a highly personalized way; (3) develop the ability to identify and measure potentially avoidable complications of therapy as well as the underlying disease process; (4) track therapeutic decision making based on nationally recognized evidence based treatment guidelines; (5) maintain a willingness to modify the process of care to improve the measured performance of physicians and support staff within the practice; and (6) consistently report physician compliance, patient compliance, clinical outcomes, economic outcomes, and patient satisfaction.."



John D. Sprandio, MD
Lead Physician, Consultants in Medical Oncology & Hematology, PC
Chief of Medical Oncology and Hematology, Delaware County Memorial Hospital
Director, Delaware County Regional Cancer Center
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"Key to serving as a medical home is providing whole person care. That means the practice is committed to helping the patient address all of their health care needs. Some specialists do this for some of their patients, but provide care of a more limited nature to many of their patients. In our experience it is important for the practice to make the commitment to serve as a medical home and have the right procedures in place for the practice to provide whole person care. Some specialists do this but it is not the norm."



Phyllis Torda
Vice President for Strategy and the Quality Solutions Group
NCQA
Washington, DC

INDUSTRY NEWS



CMS Centers for Medicare & Medicaid Services

HHS Releases State APC Announcement

Early last month HHS and CMS released the much anticipated call for State proposals for the new Advanced Primary Care (APC) Practice Demonstration medical home initiative. In six States, Medicare will join Medicaid and commercial health plans in multi-payer initiatives to improve primary care. The three-year demonstration will begin January 1, 2011. Applications are due by August 17, 2010 and interested States must demonstrate that their program is in place or will be fully in place in 2010. Applications must also demonstrate Medicare budget neutrality. See www.cms.gov/DemoProjectsEvalRpts.

MATHEMATICA
Policy Research, Inc.

New Policy Brief on Medical Home

The sixth in a series of *Mathematica* policy briefs on health reform issues deals with the medical home. The brief, entitled "Medical Homes: Will They Improve Primary Care," highlights the successes, challenges, and future of medical homes. See <http://www.mathematica-mpr.com>.



Carilion—Virginia Tech Medical Home Workshop

Carilion Clinic, featured in the June issue of *Medical Home News*, and the Virginia Tech National Capital Region sponsored a day-long workshop on the medical home on June 30. Phyllis Torda from NCQA and Paul Grundy, MD joined a variety of local officials and representatives from all branches of the military in talking about the history, structure, benefits, and evaluation of the patient-centered medical home.

At Carilion Clinic, a pilot site in Vinton, VA, was recognized by NCQA as a Level 3 medical home in October 2009, five other sites are currently undergoing NCQA review, and ten more will seek recognition in September 2010.

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AAP Mental Health in Primary Care Toolkit

The American Academy of Pediatrics (AAP) Task Force on Mental Health is releasing the Addressing Mental Health Care in Primary Care: A Clinician's Toolkit this month. This toolkit brings together ready-to-use resources and tools on a CD-ROM. Included are screening and assessment instruments, quick-reference care management advice, step-by-step care plans, time-saving documentation and referral tools, coding aids, billing and payment tips, parent handouts, and much more. See www.aap.org.



HealthAffairs

Small Physician Practices Sharing Resources

In a June 8 article in Health Affairs, Melinda Abrams and colleagues from The Commonwealth Fund describe how small physician practices can pool resources to meet the demanding requirements of a medical home. Practices may share technical or administrative resources, outsource certain clinical services, or collaborate on quality and efficiency. See www.commonwealthfund.org.



Lessons, Recommendations from AAFP Demo

A special supplement to the May/June 2010 issue of the *Annals of Family Medicine* contains eight articles highlighting various aspects of the AAFP's three-year National Demonstration Project (NDP) on the patient-centered medical home. The project, which ended last year, involved a mix of 36 different practices nationwide seeking to transform to medical homes, half self-directed and half facilitated by AAFP subsidiary TransforMED.

The evaluations reaffirm that transformation is difficult, especially around IT, and too difficult to accomplish within two years. Patient outcomes increased slightly in both self-directed and facilitated practices, but overall patient satisfaction actually decreased slightly, perhaps because so much time and attention was being devoted to the needs of the transformation processes. Find links on the *Annals of Family Medicine* web site: http://www.annfam.org/content/vol8/Suppl_1/.



Patients Like but Don't Understand EHRs

An online survey of 2,180 adults conducted by Harris Interactive for Xerox found that a majority of Americans believe EHRs will make health care more efficient, but only 16% had been approached by their provider to talk about the benefits. Of those who expressed concerns about EHRs, the greatest number (79%) worried about stolen records, followed by misuse (69%) and lost or damaged records (68%). See <http://www.xerox.com/feed/xerox-bpo>.



NCQA-HIMSS Fact Sheet on the PCMH

NCQA and HIMSS have prepared a joint fact sheet entitled "Leveraging Health IT to Achieve Ambulatory Quality: The Patient-Centered Medical Home (PCMH)." The 13-page document provides an overview of the patient-centered medical home from the health care practice viewpoint, highlights the beneficial use of health IT and the recognition requirements, and explains how health IT helps practices in the function of a PCMH, including case examples. See www.ncqa.com.

INDUSTRY NEWS



Annals of Internal Medicine

Medical Homes in Vulnerable Neighborhoods

A Commonwealth Fund supported study published in the *Annals of Internal Medicine* last month reported that primary care practices in Massachusetts that serve neighborhoods with high percentages of racial and ethnic minorities or economically disadvantaged residents were more likely than others in the State to have several key components of medical homes. In practices serving a disproportionate share of racial minorities, 80% had a multilingual clinician vs. 51% for other practices; and 48% had a frequently used, multifunctional electronic health record vs. 29%. The differences were smaller but still significant for practices serving a disproportionate share of economically disadvantaged patients. See *Annals of Internal Medicine*, June 14, 2010 170(11):938–44 or www.commonwealthfund.org.



Prevea Health PCMH Shows First-Year Results

Prevea Health, based in Green Bay, WI, began a patient-centered medical home pilot for 30-50 patients with chronic conditions at its East Mason Health Center in Green Bay a year ago. In its first six months, the center saw a 12% improvement in the number of patients in the pilot group who had their diabetes under control, and all diabetic patients in the group showed improvement. The center is now recognized by NCQA as a Patient-Centered Medical Home and plans to enroll more patients. The system also hopes to expand the medical home concept to other clinics in the future.



HHS Allocates Primary Care Workforce Funds

On June 16 HHS Secretary Kathleen Sebelius announced the availability of \$250 million to increase the number of health care providers and strengthen the primary care workforce. This is the first allocation from the new \$500 million Prevention and Public Health fund for FY 2010 available under PPACA. The allocations are: \$168 million to train more than 500 new primary care physicians by 2015; \$32 million to train more than 600 new physician assistants; \$30 million to encourage over 600 nursing students to attend school full-time; \$15 million for 10 nurse-managed health clinics to assist in training nurse practitioners; and \$5 million for states to plan and implement innovative strategies to expand their primary care workforce by 10 to 25 percent over 10 years.



BCBSM Designates 1,800 PCMH Physicians

Blue Cross Blue Shield of Michigan recently announced the designation of more than 1,800 physicians in roughly 500 practices across the state as patient-centered medical homes, a roughly 50% increase over 2009. About 5,000 doctors are attempting designation as part of Value Partnerships, a set of collaborative initiatives among physicians, hospitals, and the plan. The BCBSM PCMH program considers both process of care and performance to designate physicians. Half the designation score is based on such things as 24-hour telephone access and use of disease registries; the other one-half is based on quality and utilization measurements. See www.bcbsm.com.

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Catching Up With ... A. John Blair, III, MD, FACS

Dr. John Blair, a board-certified general surgeon, is President of the Taconic IPA, a nearly 4,000-member physician organization in the Hudson Valley region of New York. He is also Chairman and CEO of MedAllies, an information services provider which built and operates the Hudson Valley Health Information Exchange, connecting health care stakeholders in the Taconic Health Information Network and Community (THINC). He is nationally recognized for his commitment to IT-enabled advances in health care safety and quality and to the medical home model. He talks about technology, incentives, meaningful use, the medical home, and himself.

A. John Blair, III, MD, FACS

- Chairman and CEO, MedAllies (2001-Present)
- President, Taconic IPA (2000-Present) and Managing partner, Hudson Valley Surgical Associates (1985-2000)
- National advisory positions related to health IT with ONC, CCHIT, NQF, NCQA, and the PCPCC
- Recipient of the Healthcare Informatics' Healthcare IT Innovator award
- MD degree Rush Medical School; surgical training University of Texas Medical Center; gastrointestinal fellowship, Middlesex Hospital, London

Medical Home News: *You have been building the groundwork for THINC since 2003, and one of the early challenges was getting competing health plans to participate with financial incentives so there was enough money to motivate physician participation. What was the tipping point in this process? And do you expect to add State Medicaid and even Medicare?*

John Blair: There were two tipping points. In 2003, we were able to make a case to the competing health plans to come to the table to discuss the concept of creating a coordinated incentive program. Since that time we have had a fair amount of employer interest, specifically IBM's Paul Grundy and Andy Webber from the National Business Coalition on Health, that helped us get the leadership of several health plans to begin discussions within a loosely structured group initially called the EHR collaborative. Over six years we met informally and looked at incentives for e-prescribing, and then for EHR adoption. But the second tipping point came when we went from payment for infrastructure to payment for transformational change based on NCQA medical home recognition of at least Level 2. Now six health plans and one large employer are making payments for NCQA recognition as of 2009. We're raising the bar this year with a specific focus on care coordination. Independent of our work, New York Medicaid decided to pay for medical home transformation on a per-member, per-month basis, also based on NCQA recognition. So our physicians and community health centers benefit from this as well.

Medical Home News: *Getting the right electronic health record for physician practices, particularly smaller ones, seems to be a continuing challenge. How do you think the EHR vendor community is doing generally in designing products that are affordable, easily inter-operable, and user-friendly?*

John Blair: Our experience has been quite the contrary. We have implemented EHRs with nearly 600 providers, 237 of which have made NCQA Level 3 medical home recognition using these systems. We have found several EHR products that are imminently usable by small practices, including solo practitioners. In fact, we have around 30 solo practices fully using interoperable EHRs. The difficulty is not product availability; it's more an issue of providing ongoing, continuing implementation effort and robust support of the practices. EHR adoption probably is a struggle for everyone at first, but it is certainly achievable for practices of all sizes. The rate of acceleration of improvement in the products is increasing now that they are more focused on the clinical side and the physician user interface piece.

Medical Home News: *Many reports have underscored how difficult the medical home transformation process is, even with a multi-year horizon. What have been the biggest challenges that the Taconic IPA physicians have faced in this regard?*

John Blair: The documentation necessary for NCQA recognition is a fair burden for small practices that are tight on staff and infrastructure. Moving to open access and a true team-based approach is also tough for them. With our project, we purposefully selected several solo practitioners, and they made it, but only with significant support. Even very advanced practices already functioning well on EHRs took a solid year of significant effort to get there. This is hard work indeed.

Medical Home News: *There has been pushback from provider organizations regarding the requirements and timetable for demonstrating "meaningful use" of health care IT. The ONC office recently responded with a request for "bold incrementalism" by providers. How do you see the Hudson Valley practices doing in terms of qualifying for incentives?*

John Blair: I think we are well positioned because several of the components of meaningful use are already part of our standard implementation. The "bold incrementalism" piece is something I understand and is reflected in the way we've taken on all comers for EHR implementation -- small and large practices, community health centers, hospital-owned and private practices. Our next step after EHR implementation was transformation to Level 3 medical homes. Now we are connecting all these providers for enhanced health information exchange. So incremental advancement is something we understand well.

Medical Home News: *We tend to think of medical homes with commercial health plan partners in terms of direct patient care for insured patients, but you are also consciously building in a public health component. Can you talk about your vision here?*

John Blair: For us, community health centers have been an integral part of our effort from the outset, including governance, medical director input, EHR implementation, and medical home transformation. If you don't have them as part of your vision, you're not completely addressing the community's needs. And we have both learned from each other. When we started, it was funny how everyone thought that everyone else had it easier. That difference has melted away as we discovered that everyone had plenty of their own headaches. On the public health front, we do public reporting from all settings, and the New York State Department of Health and local health commissioners are actively involved in this project. Our activities are also independently studied and published by researchers at Weill Cornell Medical School.

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

John Blair: Very few people know that a few months ago I was in New Zealand on a canyoning trip, freefalling on waterfalls that were over 100 feet tall.