Volume 1, Number 10 December 2009

Medical Home NEWS

The Medical Home – Redesigning Healthcare by Starting with the Patient

By Dr. John Kenagy

The healthcare reform effort inching its way through Congress reveals the fatal flaw in our efforts – the current system is perfectly designed to deliver less care at more cost. This mismatch between care and cost is not a new one, but again and again we have failed to solve it. Now, the stakes are higher than ever. President Obama recently declared the skyrocketing cost of healthcare as the biggest threat to our nation's balance sheet.

Could our solutions be part of the problem? As a physician, healthcare executive, management scholar, author, advisor, and patient, I have watched us repeat – and fail with – the same solutions over and over again. In my 40 years in healthcare, I have experienced every solution currently under debate in Washington: managed care; payment reform; more computers and technology; more regulation and better compliance; more efficient management of hospitals, doctors, and nurses; mergers, acquisitions, consolidation, cost cutting, and downsizing; and care rationing. All have failed. Hence the result we have all experienced – less care at more cost.

All of these solutions share a common characteristic. They start big. In an attempt to tackle the big problems of healthcare, they involve big efforts to collect and analyze lots of data, consult lots of experts, conduct lots of meetings to analyze, plan and predict, and finally design and implement a big solution.

continued on page 7

In This Issue

It's a Beautiful Day in the Neighborhood … Won't You Be My Neighbor?

By Deb Barnett, RN, MS, FNP, Karen Frederick-Gallegos, Raquel Alexander, MA, Angel Perez, RN, BSN, and Julie Schilz, RN, MBA

We dream of a beautiful day in the neighborhood…when reimbursement covers much needed between visit care...when all health information is available when needed and accessible to everyone sharing care for a patient …when a system is structured to absorb the impact of addressing care needs for all…when providing care that prevents chronic disease and poor clinical outcomes is rewarded instead of thwarted…when all parties involved, including the patient and family, can be engaged and on the same page. Can we go there together? Will you be my "neighbor"?

The patient-centered medical home (PCMH) with its footing firmly planted on the tenets of both the Primary Care and Chronic Care Models[1], has its lifeblood in a larger landscape—a fully integrated and functioning Medical Neighborhood. With its original framework based on observations posed in Wagner's "It Takes a Region,[2]" the Medical Neighborhood involves a larger systems-level view of the medical home model which characterizes the relationships and external structures necessary for the PCMH to be sustainable at the practice level. (For a schematic showing the various roles and relationships before, during, and after a patient visit, see http://coloradoguidelines.org/pdf/pcmh/pcmh_care_plan.pdf.)

[1] Center for Studying Health System Change. (2008). Building medical homes on a solid primary care foundation. Policy Perspective: Insights into Health Policy Issues, 1, 2-8.

[2] Wagner, E. et al. (2006). It takes a region: Creating a framework to improve chronic disease care. The McColl Institute for Healthcare Innovation/The California HealthCare Foundation. pp 1-31.

continued on page 5

Publisher
Clive Riddle, President, MCOL

Editor
Raymond Carter

Medical Home News is published monthly by Health Policy Publishing, LLC. Newsletter publication administration is provided by MCOL.

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

Editor's Corner

Raymond Carter, Editor, *Medical Home News*

It is my pleasure this month to introduce *Medical Home News* Advisory Board member Dr. Salvatore Volpe.

Salvatore Volpe, MD, FAAP, FACP, CHCQM
NCQA Level 3 Recognition - PPC®—PCMHT
Solo Practice
Chairman of MSSNY HIT Task Force
Staten Island, NY

With over 19 years of primary-care practice experience, Dr. Salvatore Volpe is one of the few physicians in the country to have successfully become board certified in pediatrics, internal medicine, geriatrics, and quality assurance. His solo practice is limited to adolescent, internal, and geriatric medicine. His is the first solo practice (and one of three practices in total) in New York to receive Level 3 recognition by NCQA, the highest level of recognition achievable

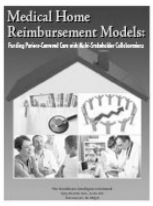
In 2007, Dr. Volpe received that year's Quality Award from IPRO, New York State's Medicare Quality Improvement Organization, which recognizes health care providers who demonstrate a commitment to improving health care services in the state. Dr. Volpe currently works with the NYC DOH Primary Care Information Project (PCIP) to facilitate the adoption of electronic health records and lectures throughout New York for the Medical Society of the State of New York as Chair of the HIT Task Force.

As President of the HIMSS NYS Chapter, Dr. Volpe is working to bring the various member constituencies together to for the optimal use of healthcare information technology (IT) and management systems for the betterment of healthcare.

Dr Volpe has also begun to offer consultative services to groups and health plans seeking to promote the Patient-Centered Medical Home.

Medical Home Book of the Month

Medical Home Reimbursement Models: Funding Patient-Centered Care with Multi-Stakeholder Collaborations is a 36-page special report that presents three ongoing medical home pilots in Colorado, Ohio and New Hampshire , built on a variety of reimbursement models. Order at: http://store.hin.com/product.asp?itemid=3864.



SUBSCRIBER'S CORNER

Is there an article you particularly liked? Or perhaps disagreed with? A topic you haven't seen covered but think we should pursue? Let us know. We would like to see this section of *Medical Home News* grow into a commentary and suggestion segment. Remember, you can receive each issue of *Medical Home News* via email in an electronic PDF version, via regular mail in print version, or both. Please contact us at any time at www.MedicalHomeNews.com regarding your subscription.

SAVE THE DATE
National Medical Home Audioconference
The Role of the Hospital in the Medical Home Movement: Primary Care Recruitment, HIT Support for Affiliated PCPs, Managed Care Network Building
Wednesday, January 13, 2010 • 1:00pm – 2:30pm Eastern
www.MedicalHomeAudioconferences.com

Medical Home Poll Shows Heightened Activity, Belief in Cost Savings, Concern about Payment

By Raymond Carter, Editor, and Clive Riddle, Publisher, Medical Home News

Medical Home News periodically will provide exclusive results from a survey of professionals conducted by MCOL on various issues that relate to the Patient-Centered Medical Home. Survey participants typically have a more active interest in Medical Home issues. The following e-survey was conducted in conjunction with the National Medical Home Web Summit on October 29, 2009. The number of respondents was 118.

We asked participants to respond to four items:

1. Please categorize your organization.
2. During 2009, how has your organizations involvement with medical home issues changed from 2008?
3. Do you think that widespread adoption of the medical home model would increase quality and lower costs, increase quality but also increase costs, or have no effect on quality?
4. What is the single most important issue to overcome in terms of widespread implementation of the medical home model: (a) growing shortage of primary care physicians; (b) lack of sufficient incentives to adopt and implement EHRs; (c) lack of sufficient team culture being taught in medical schools and residency programs; (d) or lack of payor commitment to reimburse care coordination?

Here's what we found:

Overall, just over three-fourths of respondents indicated that their own organization's activities and initiatives related to the medical home had increased from 2008 to 2009, while 16.2% experienced no change. The remaining 8.5% basically said the question did not apply to them. There were no respondents who felt that their organization had decreased its involvement in this area. (See Figure 1 below) Factoring out organizations that did not find this question to be applicable, the re-calculated overall totals showed just over 82% with increased activity, as detailed in Table 1 below.

Figure 1

Own Organization's Involvement in MH Activity -- 2009 vs. 2008

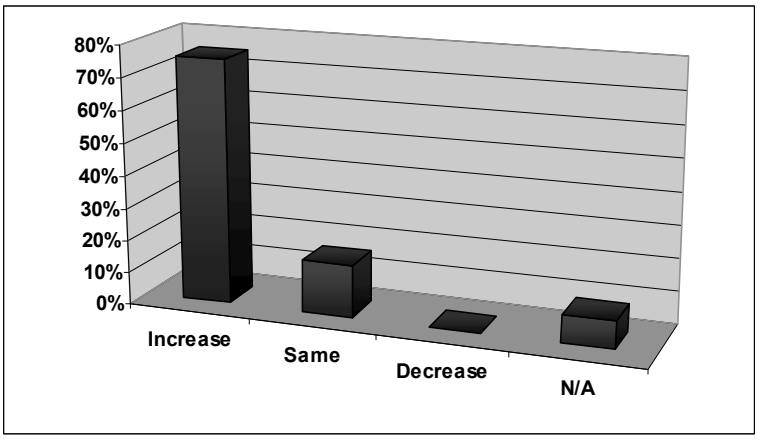


Table 1
Own Organization's Involvement in MH Activity -- 2009 vs. 2008

	2009 vs. 2008%
Increase	75.2%
Same	16.2%
Decrease	0.0%
Not Applicable	8.5%
Total	100.0%
Responses Excluding "Not Applicable"	**2009 vs. 2008 %**
Increase	82.2%
Same	17.8%
Decrease	0.0%
Total	100.0%

In terms of organizational category, the increased activity was perhaps not surprisingly strongest among providers. However, increased activity was also significant among vendors and payors as well, as shown in Table 2.

Table 2
Own Organization's Involvement in MH Activity -- 2009 vs. 2008: Responses by Organizational Category

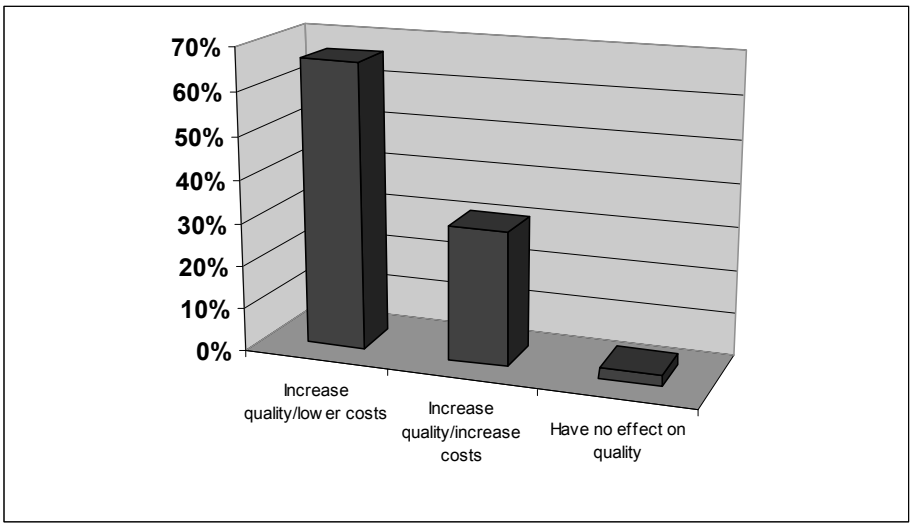
Response	Payors	Providers	Vendors	Total
Increase	56.5%	82.5%	74.2%	75.2%
Same	30.4%	9.5%	19.4%	16.2%
Decrease	0.0%	0.0%	0.0%	0.0%
Not Applicable	13.0%	7.9%	6.5%	8.5%
Grand Total	100.0%	100.0%	100.0%	100.0%

continued on page 4

Medical Home Poll Shows Heightened Activity*...continued*

In terms of what respondents thought adoption of the medical home model would accomplish, significantly nearly two-thirds thought that widespread implementation of Patient-Centered Medical Homes would both increase quality *and* lower cost. A total of 31% thought such adoption would increase quality but also increase cost. Only 2.6% of respondents thought such widespread adoption would have no effect on quality. Figure 2 shows the details graphically.

Figure 2: Effect of Widespread Adoption of the Medical Home



Interestingly, there was very little variation in these opinions across organizational categories. Vendors showed the greatest faith in the ability of the medical home model to reduce costs as well as increase quality, and providers showed the most concern about costs increasing, but the percentages were remarkably similar, as shown in Table 3.

Table 3
Effect of Widespread Adoption of the Medical Home Model: Responses by Organizational Category

Response	Payors	Providers	Vendors	Total
Increase quality and lower costs	65.2%	65.1%	70.0%	66.4%
Increase quality but also increase costs	30.4%	33.3%	26.7%	31.0%
Have no effect on quality	4.3%	1.6%	3.3%	2.6%
Grand Total	100.0%	100.0%	100.0%	100.0%

This similarity in belief was definitely not present when it came to picking the most important obstacle to overcome. Overall, more than half of the respondents -- 57.3% -- felt that a lack of payor commitment to reimburse care coordination was the single most important issue to overcome for implementation of the medical home model. Other issues were chosen by a much smaller percentage of respondents, with 20.5% pointing to a growing shortage of primary care physicians, 12% focusing on a lack of sufficient team culture being taught in medical schools and residency programs, and 5.1% looking to the lack of sufficient incentives to adopt and implement EHRs. The combined responses are shown (next page) in Figure 3 and in Table 4 (in the Total column.)

When broken down by organizational category, however, some dramatic differences of opinion emerged. Providers and Vendors were more than twice as likely as Payors to point to a lack of payor commitment to reimburse care coordination as the major hurdle, their percentages reaching nearly two thirds. Payors, for their part, were largely split between that issue and the issue of a growing shortage of primary care physicians as their primary concern. The details are also illuminated in Table 4 (next page.)

continued on page 5

Medical Home Poll Shows Heightened Activity*...continued*

Figure 3: Most Important Issue for Medical Home to Overcome

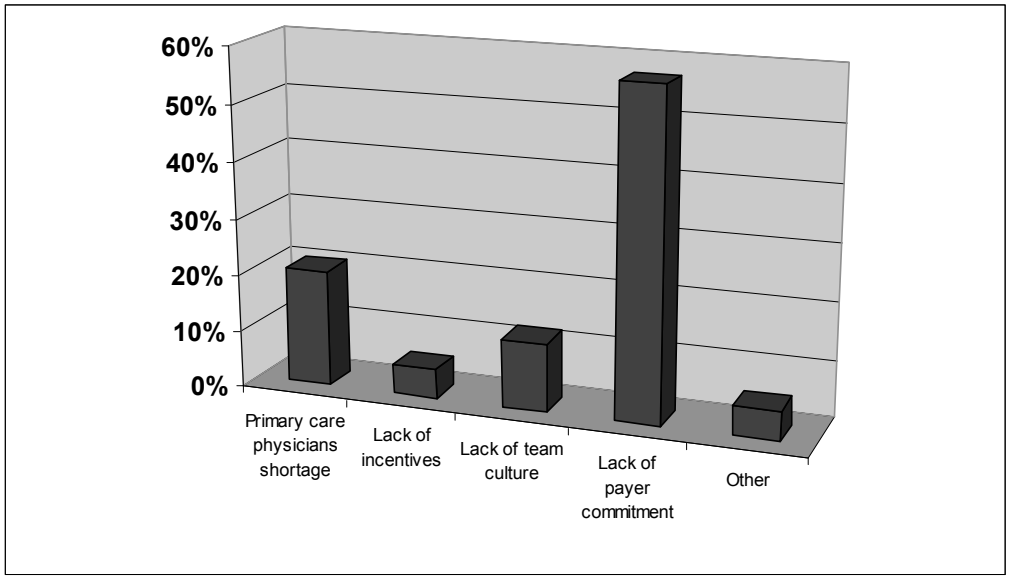


Table 4: Most Important Issue for Medical Home to Overcome Responses by Organizational Category

Response	Payors	Providers	Vendors	Total
Primary care physicians shortage	30.4%	21.9%	10.0%	20.5%
Lack of incentives	8.7%	4.7%	3.3%	5.1%
Lack of team culture	13.0%	6.3%	23.3%	12.0%
Lack of payer commitment	30.4%	64.1%	63.3%	57.3%
Other	17.4%	3.1%	0.0%	5.1%
Grand Total	100.0%	100.0%	100.0%	100.0%

The breakdown of respondents by general category (N = 118) was: Payor - 19.5%; Provider - 54.2%; Vendor/Other - 26.3%

It's a Beautiful Day in the Neighborhood*...continued*

> *"Too often we are so busy that patients need to coordinate their own care, which can lead to significant communication and follow up issues. The Medical Neighborhood includes 'anyone that touches the patient' – specialists, mental health providers, hospitals, home health providers, case managers, pharmacists, other community resources, and family members – all working in an integrated, coordinated fashion, to help ensure patients get the care they need when they're sick, but even more importantly, helping them stay healthy," comments Dr. Marjie Harbrecht, Executive/Medical Director for CCGC.*

Recognizing that there are plenty of barriers to broad scale PCMH implementation, including a need for resources as well as basic information, the Colorado Medical Society (CMS) and the state chapters of the primary care societies are working together in a broader "Systems of Care" project to engage primary and non-primary care practices to support adoption of the patient-centered medical home approach and the advancement of the "medical neighborhood" concept. "The 'Systems of Care' initiative brings all the specialties together for a conversation within the family for the purpose of breaking down care silos and improving care," says Chet Seward, Senior Director of Health Care Policy at CMS. Born in the minds of CAFP leaders, the project will support the process of gathering statewide physician feedback on challenges for implementing the PCMH and use physician and consumer input to help develop a meaningful strategy for approach and development of resources—for both physicians and consumers. This initiative was generously funded by the Colorado Health Foundation, a philanthropic organization dedicated to improving the health of Coloradoans by investing in programs that improve access, quality, and coordination of care to the medically under-served. Anne Warhover, president and CEO of the Colorado Health Foundation states:

continued on page 6

It's a Beautiful Day in the Neighborhood*...continued*

> *"The patient-centered medical home model has the potential to transform and improve the delivery of health care by emphasizing care coordination, preventive care and promoting quality improvement. The outreach to and involvement of Colorado's physicians is vital to this effort's success because the transformation may start with primary care practices, but must include specialists in order to fully realize the potential of the medical home."*

A statewide poll surveying Colorado's primary care and specialist physicians, hosted by the Colorado Medical Society in September 2009, solicited opinions concerning the patient-centered medical home and coordination of care. Results highlighted that there is a broader readiness than anticipated around interest in the medical home, as 56% of Colorado PCPs surveyed said that they will definitely or probably become a PCMH, while 78% of specialists strongly or somewhat agree that there are steps their practices can take to support medical neighborhoods. Both primary care and specialists prioritized patient outcomes, patient satisfaction, and care coordination as compelling reasons to become or work with a medical home.

The project also features the hosting of focus groups, two summits, and the use of Resource Advisors. The first phase of work for the "Systems of Care" project culminated in a weekend summit in late October. The Summit was attended by over 35 physician leaders from across the state of Colorado representing 17 component or specialty societies. The purpose of the summit meeting was to initiate dialogue between primary care and non-primary care physicians about the imperative for delivery system reform using the Patient-Centered Medical Home approach and a "building the medical neighborhood concept."

During the summit, the group in attendance reviewed the current Colorado and national landscape, analyzed the results of a statewide poll collected by CMS looking at Colorado physician perceptions of the PCMH, and developed a shared understanding of PCMH and medical neighborhood concepts for the purposes of developing a state level action plan for moving this approach to care forward and participating in system-level redesign efforts.

The Resource Advisors, trained by Colorado Clinical Guidelines Collaborative (CCGC), will have the role of outreaching to practices for educational and initial assistance in finding ways to take a step toward engagement in patient-centered medical home activity. The Colorado Academy of Family Physicians (CAFP), Colorado Society of Osteopathic Medicine (CSOM), the state chapter of the American Academy of Pediatrics, and the Colorado Medical Society each have their own Resource Advisor who will be tasked with reaching each organization's respective constituents. Though each of the models for outreach are somewhat different, the Resource Advisors have in common the priority goal of assisting Colorado physicians and practices who are ready to take the next step and linking them to appropriate resources for moving along the continuum for adopting the PCMH approach.

In the midst of what seems like rapid mobilization and alignment for practice transformation and health care reform in not only the state of Colorado, there is an important player who needs to stay in the center of the Medical Home and the Medical Neighborhood – and that player is the patient. Eileen Forlenza, Director of the Colorado Medical Home Initiative housed at the Colorado Department of Public Health and Environment (CDPHE) comments,

> *"The key to the PCMH is acknowledging that the patient is a necessary participant on the health care team. Health and health care are a personal experience for the patient, and unfortunately that experience is often lost in the delivery process of those health care services. Elevating the patient's role in the delivery of health care by placing the patient in the center of their care, while promoting a healthy balance between personal responsibility and a coordinated health care team can promote healthier outcomes for everyone. That is the benefit of the PCMH and why it is leading change in the approach to delivering quality health care."*

There is significant state-level momentum in Colorado to drive health care reform. Initiatives such as Governor Bill Ritter's Center for Improving Value in Health Care (CIVIHC), Colorado's Department of Health Care Policy and Financing (HCPF)'s ongoing work in creating statewide Accountable Care Collaboratives, and Colorado's recent submission for Federal Funding to establish a Regional Extension Center supporting statewide EHR adoption and the development of HIE, aim to align incentives for real system change. The "Building Systems of Care" initiative is the next step in a larger, strategic push by organized medicine in Colorado to reform the system from the bedside up. This initiative can be used as a vehicle to improve coordination and value and to encourage physicians around the state to engage in the activities of the grant and assume a leadership role in reforming the delivery system.

continued on page 8

The Medical Home – Redesigning Healthcare*…continued*

The Medical Home provides a framework for doing exactly the opposite. Unlike the big solutions that have failed and will continue to fail, the Medical Home creates the opportunity to start small – with the patient. Therefore, following the course of successful innovators, the development of the Medical Home can be the vehicle for a transformational solution for healthcare.

Lessons from great innovators.

As a Visiting Scholar at Harvard Business School, I discovered that successful transformations follow a predictable course: a small number of leaders steadily adapt their organizations to deliver what the rest cannot. Harvard Professor Clayton Christensen's model of disruptive innovation tells that story over and over again. Toyota did not design and implement the Toyota Production System or the downfall of GM; they made it happen from the ground up. Southwest Airlines did not design and implement the world's most profitable airline; they made it happen from the ground up. And those are just two of hundreds of examples.

My research showed that the few organizations that were able to continually adapt when others failed did so by building the capability of the people within their organization to fix small problems as they occurred very close to the customer and then replicating the solutions until the problems stopped appearing altogether. These great, transformative innovators shared a few common characteristics that led to their success. For the last 12 years, those characteristics have been tested, validated, and improved in the crucible of the world's most dynamic, complex, and unpredictable business – U.S. healthcare. The result is a methodological approach to continuous innovation called Adaptive Design® and the subject of my new book "Designed to Adapt: Leading Healthcare in Challenging Times."

Through the Medical Home, Adaptive Design can help healthcare transform itself to provide more care at less cost, just like Toyota or Southwest Airlines successfully transformed automobile production and transportation services. Below, I outline three of the key factors for adaptive success applied to the Medical Home concept.

Leadership sets a clear, simple, consistent, meaningful direction.

Leadership is important because a successful Medical Home will need to develop, coordinate, and improve the work of many different people to be able to meet the complex needs of patients. In my research, great adaptive leaders marshal the diverse forces of disparate people to a common purpose by setting a clear, consistent, meaningful direction for the organization to meet the underserved needs of customers.

The Medical Home is uniquely positioned to set that direction because it understands clearly that "customers" are not the doctors, managers, health plans, hospitals, government, or some scorecard. The customer is the patient. Making that message clear, consistent, and meaningful is essential to adaptive success.

Therefore, a key for success for Medical Home leadership is to direct their organizations to focus on just one thing. My book details one example of a clear, simple meaningful direction that has been extensively tested and proven at the point-of-care: Ideal Patient Care®." Ideal Patient Care means providing exactly what's needed, exactly when and where it's needed. Not more, and certainly not less; just what's needed for each patient now. That care should also be customized individually; immediately responsive to problems or changes; safe – physically, emotionally and professionally – for all, including the caregivers; and not waste any resource. Once people in the Medical Home know where they are going, the next question to answer is, "How will they get there?"

Develop people, not technology, as the #1 resource.

How does the "system" improve? The current big problem/big solution mindset would suggest technology is the answer. So let's look at the leaders of three great technology companies – Bill Gates of Microsoft, Andy Grove of Intel, and William Hewlett and David Packard, the "Bill and Dave" of Hewlett-Packard.

Since these leaders developed or led great technology companies, their focus must have been on technology. Right? Wrong! Their great technological success came from trivial technologies. For example, Bill Gates bought DOS from Seattle Computer Company for $50,000. Intel reportedly developed their gigantic microprocessor business based on a $60,000 special order from a Japanese calculator company. Hewlett and Packard started in a garage. But they all had one thing in common: each of these leaders was fanatical about bringing out the best in their people. It's developing people, not technology, that make the difference. The same is true in the Medical Home. But how can the Medical Home develop people as the #1 resource?

Don't design and implement; rather develop people, skills, and tools to problem solve when systems fail as part of everyone's daily work.

The Medical Home must make improvement part of every day work. People must be given the methods, skills, and tools to problem solve in real time when systems fail. Part of my Harvard research was working directly with Toyota experts in healthcare. I discovered that Toyota is much more than a set of Lean process improvement tools. Rather than design and implement perfect processes, Toyota focuses on identifying when processes fail as a problem to be solved utilizing the knowledge and creativity of those close to the problem to create a solution in the course of everyday work.

continued on page 8

The Medical Home – Redesigning Healthcare*…continued*

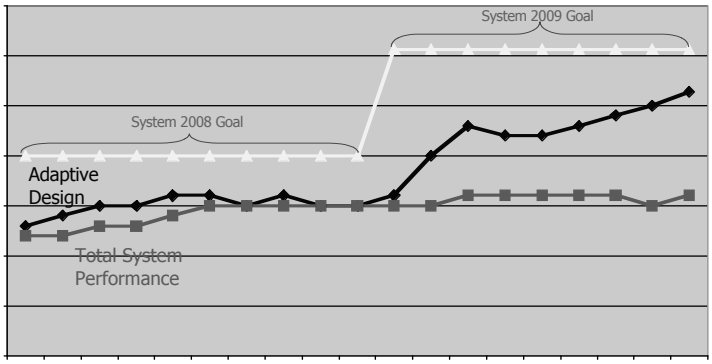
Staff and physicians of a Medical Home can likewise identify when patient care is not ideal and work to solve the problem immediately in the course of work. This immediate problem solving develops everyone in the organization because they discover that "Improvement" is not a project and "Quality" is not a department; it's everyone's work, every day.

This capability to do immediate problem solving has been widely tested in healthcare. Here is a primary care clinic example from a very large health system.

The focus of this health system was on specific measures of clinical performance – high reach goals in 2008 that increased in 2009. The bulk of the system slowly improved but was short of meeting targets.

In October 2008, one clinic within the system started developing the knowledge, creativity, and problem solving ability of the primary care frontline to work adaptively. Focused on improving clinical performance with immediate problem solving, they quickly began to separate themselves from the other clinics in the system.

Optimal Clinical Care
Adaptive vs. Traditional Performance



The message is clear. Big fix solutions to big problems will continue to deliver what they have always delivered – less care at more cost. The Medical Home has promise to reverse the trend and provide more care at less cost.

To make a difference, start with the patient. Set clear, meaningful direction focused on the patient. Develop people, not things, as your most important resource. Capture the knowledge, creativity and problem solving ability of everyone in your organization to continually move patient care closer to Ideal. And never stop challenging the status quo. The Medical Home can make a difference.

Dr. John Kenagy is a physician, patient, former Visiting Scholar at Harvard Business School, and author of Designed to Adapt: Leading Healthcare in Challenging Times *(Second River Healthcare Press, October 2009). He can be contacted at john@johnkenagy.com.*

It's a Beautiful Day in the Neighborhood*…continued*

In addition to the "Systems of Care" project, three Medical Home Pilots, a statewide Family Medicine Residency PMCH project (described in last month's issue of *Medical Home News*), and four CDPHE-funded community level "medical home" initiatives are testing best practices —all of which will support the work that our primary care practices are doing to transform their practices and communities into Medical Homes as part of integrated Medical Neighborhoods. There is lot of work before us in order to realize these ends, but what a victory it will be to be able to someday say, "It's a beautiful day in the neighborhood. It's great to have you as my neighbor!"

Medical Home Pilots/Initiatives in the State of Colorado

- Colorado Medical Home Initiative—*Colorado Department of Health and Environment, Colorado Children's Healthcare Access Program, Colorado Department of Health Care Policy and Financing, Family Voices*
- Multi-State, Multi-Stakeholder Demonstration Pilot—*Colorado Clinical Guidelines Collaborative*
- Family Medicine Residency PCMH Project—*Colorado Clinical Guidelines Collaborative, University of Colorado* Department of *Family Medicine, Colorado Association of Family Medicine Residency Programs, Colorado Institute of Family Medicine*
- Safety Net Multi-State Medical Home Initiative—*Colorado Community Health Network*
- "Building Systems of Care" Medical Home Initiative—*Colorado Medical Society, Colorado Academy of Family Physicians, Colorado Children's Healthcare Access Program, Colorado Society of Osteopathic Medicine, Colorado Clinical Guidelines Collaborative*

Deb Barnett, RN, MS, FNP is Coordinator, Grants Management & Program Development, Colorado Clinical Guidelines Collaborative; Karen Frederick-Gallegos is Director of Quality Initiatives, Colorado Medical Society; Raquel Alexander, MA is Executive Director, Colorado Academy of Family Physicians; Angel Perez, RN, BSN PCMH is Resource Advisor, Colorado Academy of Family Physicians; and Julie Schilz, RN, MBA is IPIP & PCMH Manager, Colorado Clinical Guidelines Collaborative. For more information on this and other Colorado medical home initiatives, contact Julie Schilz at jschilz@coloradoguidelines.org.

*T*hought Leader's *C*orner

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

Q: "Do financial incentives and public recognition motivate physicians and physician practices to change, or simply reward the ones who do?"

"In our experience, bonus payments do influence provider adoption of QI initiatives. Illinois Health Connect, a medical home program for 1.7 million Medicaid recipients, initiated a bonus payment program in 2009 targeting five measures (controller meds in asthma, HbA1C testing, mammography rates, immunization rates, and objective developmental screening.) Anecdotally, we noticed that the bonus measures received more attention than other potential clinical initiatives. In our Provider Survey over 50% of providers acknowledged that the bonus payments had stimulated QI efforts in their practices. We have a threshold program (as opposed to a competition program) where every provider who meets the criteria is guaranteed a minimum payment per patient, so practices can predict a ROI."

Margaret Kirkegaard, MD, MPH
Medical Director, Illinois Health Connect
Automated Health Systems
Schaumburg, IL

"It depends. Later generation incentives not only account for overall quality but the a) degree of improvement from baseline and b) the patient factors that also play a role in achieving success. Even with these advances, we still have a way to go because of the limitations in applying measurement to individual physicians (where statistical variation can be quite high) and the criticism that physician 'practice' changes may not necessarily lead to measurably better patient outcomes. The bottom line is that financial incentives plus public recognition is still a work in progress and will probably end up being just one tool among many in the effort to improve health care."

Jaan E. Sidorov, MD, FACP
Author, Disease Management Care Blog
Independent Health Care Consultant
Harrisburg, PA

"Historically the size of financial incentives in P4P programs has not been significant enough to capture physicians' attention. In CDPHP's Medical Home project we have created an incentive of $50,000 per MD which has certainly motivated the physicians to 'change'. It is too early in our project to conclusively determine whether the desired 'changes' are truly occurring."

Bruce Nash, MD, MBA
Senior Vice President/Chief Medical Officer
Capital District Physicians' Health Plan, Inc.
Albany, NY

"Financial incentives and public recognition do have some effect on motivating physicians and physician practices to change. This conclusion is based on five years of experience with California's Pay for Performance initiative (the largest such program in the country) and some other available evidence. However, it is difficult to disentangle the effect of financial incentives from public recognition and public reporting. Also, the effects to date have been small, and many programs are only beginning to reward improvement among the lower performers as opposed to reinforcing the superior performance of the better performers.

The biggest challenge under the increased demand likely to come from health reform is with the many smaller practices' ability to provide comprehensive patient-centered care, as called for in the Medical Home models. Incentives alone will not do it. Local physician and managerial leadership will be needed to explore new organizational forms of care and to develop the internal capabilities to respond to the new incentives and public accountability demands."

Stephen M. Shortell, PhD, MPH, MBA
Blue Cross of California Distinguished Professor of Health Policy and Management
Dean, School of Public Health
University of California, Berkeley
Berkeley, CA

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

"The short answer is yes. And we know this to be true because it's a topic that we researched extensively in the original Bridges To Excellence pilot sites. For four years we saw the number of recognized physicians steadily increase and set out to determine whether we were simply attracting the 'already good' or motivating physicians to change. We published the results earlier this year[1] and conclusively show that physicians respond to incentives. If they didn't, there would be no correlation between the amount of the incentive and the likelihood to participate."

1. de Brantes F, D'Andrea G, "Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation", AJMC 15: 305-310 May 2009, Number 5.

François de Brantes
CEO
Bridges To Excellence®
PROMETHEUS Payment®
Newtown, CT

"The physician's greatest motivation for change is improved patient care and practice satisfaction. Physicians will work to implement innovations that improve patient care through more efficiency in the front office or improved diagnostic and treatment options. Such is the case with the patient-centered medical home, designed to provide comprehensive, whole-person health care, end duplication and fragmentation, and increase efficiency of our health care system. However, with every innovation comes additional expense.

Physician practices are the only businesses that cannot defray the cost of innovation through price changes. So, although they don't drive physicians' interest in innovations, financial incentives do encourage faster adoption by easing the cost of investments in equipment such as new computer systems, in medical equipment and supplies, and in staff training to implement new care and business practices."

Lori Heim, MD
President
American Academy of Family Physicians
Laurinburg, NC

"Research by Hibbard and by Hannan shows that public clinical performance comparison, one form of recognizing high performance, does motivate performance improvement. The evidence on economic incentives is weak when rewards are a small % of total revenue, but strong when a large % of total revenue. For example, hospital length of stay reductions attributable to DRG-based Medicare payment were large and swift.

This makes the job required of health care value champions clear: foster rapid migration from pay for service volume to pay for service value. Our migration path options are publicly reported value comparisons, value-tiered insurance benefit design, and value-based provider payment methods. Most of today's local efforts are directionally right, but the relationship between provider total revenue and comparative provider value remains far too weak.

Having injected sub-clinical doses of an effective medicine, we shouldn't be surprised that our patient's condition improved very little."

Arnold Milstein, MD
National Health Care Thought Leader, Mercer
Medical Director, Pacific Business Group on Health
San Francisco, CA

"I believe that financial incentives and public recognition will at the onset reward the early adopters. These are practices that were able as a team to make the leap of faith even if it meant an initial decline in overall net income as increased resources were applied to a given population of patients. As these early adopters qualify for the pilot financial incentives, and as they receive public recognition in their community, their peers can become inspired. Many practices are struggling and may not be able to effect the necessary change in their operations until they see viable financial incentive programs in place and see that the new payment models are actually supported by the local payers."

Salvatore Volpe, MD, FAAP, FACP, CHCQM
NCQA Level 3 Recognition - PPC®—PCMHT
Solo Practice
Chairman of MSSNY HIT Task Force
Staten Island, NY

INDUSTRY NEWS

NCQA Panel to Update PCMH Standards

On November 17 NCQA announced the appointment of a panel of 23 experts who will help it update the standards for its medical home recognition program Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™). Susan Edgman-Levitan, P.A., Executive Director of the Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital, will chair the new advisory group, which will begin considering suggestions in the first quarter of 2010. Following a public comment period, NCQA will publish final standards in January 2011.

NCQA also named a task force to explore how to apply the medical home standards and other quality requirements to accountable care organizations (ACOs). This group will be chaired by Robert Margolis, MD, CEO of HealthPartners of California, and will provide additional input to the PPC-PCMH Advisory Committee. Issues to be explored will include recognition of non-physician clinicians and aligning standards with federal "meaningful use" requirements for EHRs.

BCBS Kansas City and TransforMed Launch New Pilot

Last month Blue Cross and Blue Shield of Kansas City and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians (AAFP), announced a medical home pilot program involving 13 primary care physician groups in the Kansas City area. The groups were selected for the two-year pilot in a competitive application process. TransforMed will provide practice enhancement facilitators to help the groups during the transformation process, and Blue Cross Blue Shield of Kansas City will provide financial sponsorship, including incentives. The pilot will address how plans can better reimburse physicians around quality, efficiency, and patient satisfaction goals. In turn, the program seeks to assess the effectiveness of incentives for engaging patients on healthy lifestyle choices and compliance with their care plan.

IHealthBeat Audio Report on High Tech PCMHs

The November 24 iHealthBeat update featured an audio report on high tech patient-centered medical homes as a way to curb costs and boost quality. Participating in the dialogue were Adam Bosworth, CEO of Keas, Wayne Gattinella, CEO of WebMD, and Diane Rittenhouse of the University of California-San Francisco.

New PCMH Manual for Safety Net Providers

The Primary Care Development Corporation recently released a comprehensive how-to manual for safety net providers interested in becoming recognized by NCQA as medical homes through its PPC®-PCMH™ program. The publication guides practices through every step of the process --selecting a project team, setting expectations, organizing the workload, and ultimately completing the NCQA submission form. A series of 13 appendices provides additional tools and resources. The New York City-based advocacy and technical assistance group received financial support from the New York Community Trust to produce the manual. Copies of the new manual are available for download at the PCDC web site at: http://www.pcdcny.org/go/medicalhome.

A Competency-Based Curriculum for the PCMH

The most recent issue of the Annals of Family Medicine contained a report from a Society of Teachers of Family Medicine (STFM) task force on their work to develop a competency-based curriculum for the patient-centered medical home. Begun in 2005 in response to the Future of Family Medicine report, the new curriculum is designed to offer a continuum of teaching and learning resources for predoctoral, residency, and preceptor/teacher education in four areas – group visits, advanced access, quality improvement, and the chronic care model. Each units contains model goals, objectives, evaluation materials, checklists, teaching activities, and faculty development suggestions. See the Annals of Family Medicine 7:565-566 (2009).

New Support for Better Primary Care Access

Last month the Center for American Progress, a Washington, DC-based think tank, released its own recommendations for how to ensure an adequate supply of primary care physicians and primary care access. The key proposals were to (1) expand the National Health Service Corps to help community health center staffing; (2) change the way public and private insures primary care physicians to incent team care and a focus on patient outcomes; and (3) widen the role of nurse practitioners and physician assistants. See www.americanprogress.org.

Catching Up With …

Phyllis Torda -- Senior Executive, Strategic Initiatives, National Committee for Quality Assurance (NCQA), Washington, DC. Phyllis Torda is responsible for NCQA's strategic planning and for leading cross-cutting projects of strategic significance. These include efforts to promote the patient-centered medical home, to evaluate Medicare Special Needs Plans for CMS, and to identify opportunities created by health reform legislation. She talks about recognition, incentives, patient outcomes, and an unusual personal skill.

Phyllis Torda

- Vice President for Product Development, NCQA (1997-2007)
- Assistant Vice President for Federal and State Projects, NCQA, 1995-97
- Director, Health and Social Policy, 1988-1995, Families USA Foundation, Washington, DC
- Coordinator for Health Policy, Health Policy Specialist, American Federation of State, County and Municipal Employees, Washington, DC, 1982-1988
- Invited member, AHIC Quality Workgroup, Office of the National Coordinator for Health Information Technology, DHHS; invited member,
- Technical Advisory Group, AHRQ/CMS/Ambulatory Quality Alliance, Data Aggregation Pilots
- BA in Sociology, Vassar College; MA in History, University of Wisconsin, Madison; all requirements for Ph.D. completed (except dissertation), University of Wisconsin, Madison

***Medical Home News**: NCQA started out with diabetes as the first physician practice recognition program, later adding heart/stroke care and more recently spine care. Are there other condition-specific recognition programs in the works?*

Phyllis Torda: At the moment we are focused on updating our Patient-Centered Medical Home requirements and on updating our measurement specifications for reporting by EHRs to meet "meaningful use" reporting requirements under ARRA (stimulus bill), and not on creating new condition-specific programs. We are excited about the opportunity to use EHRs to address quality issues that have not been possible to address otherwise.

***Medical Home News:** Our Thought Leader question of the month asks whether incentives and recognition really motivate physician change or simply reward the early adopters. What's your take?*

Phyllis Torda: I've seen the availability of incentives, in Pennsylvania for example, motivate practices to make the changes necessary to become recognized as medical homes and therefore eligible for additional reimbursement. Many practices may be willing to make changes, but would not do so without knowing that additional financial compensation will be available. These changes cost money, and primary care practices are financially strapped.

***Medical Home News** Outside of Bridges to Excellence, are there self-insured employers or commercial or public health plans that offer bonuses to doctors based on their achieving NCQA recognition?*

Phyllis Torda: Many plans offer favorable treatment to NCQA recognized physicians. They feature the information in provider directories, they use it to qualify physicians for preferred tiers, and they use it as a basis for increased payment.

***Medical Home News** Have you studied the difference in patient outcomes for diabetes patients, for example, who have been seen by NCQA-recognized doctors vs. a control group?*

Phyllis Torda: We have not done a formal study, but we believe there is good evidence that systematic care of patients with diabetes or cardiovascular disease (the chronic care model) leads to better outcomes; that's why we use the process measures that we do. The scoring for the recognition programs is also weighted towards the outcome measures, and Bridges to Excellence pays extra for physicians meeting the required percentages for outcome measures.

***Medical Home News** NCQA has just announced some new developments in its PCMH recognition program. What lies ahead in the next version of PPC-PCMH?*

Phyllis Torda: Now that the current requirements have been in place for almost two years and have attracted so much interest from practices and others, we are eager to think about what the next version should look like. What are appropriate requirements for practices that will need to renew their Recognition? How can we make the requirements more patient-centered? What should we require in terms of clinical results? Will new federal standards for exchange of information make it possible to have more ambitious requirements for communication with specialists and hospitals? How should requirements for primary care practices relate to requirements for multi-specialty practices and fully integrated systems that want to function as Accountable Care Organizations? We will be tackling these issues with a multi-stakeholder advisory committee. We will hold a public comment period on draft new requirements next Spring and release the next version(s) very early in 2011.

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

Phyllis Torda: My husband and I have just earned our third certificates in Japanese flower arranging (Ikebana), Sogetsu School (there are a number of different "schools" or styles). Each certificate takes about a year.