

Medical Home NEWS

America Awakens to the Patient Centered Medical Home

By Paul Grundy, MD, PCPCC President and IBM's Director of Healthcare, Technology and Strategic Initiatives for IBM Global Wellbeing Services and Health Benefits, and Edwina Rogers, JD, Executive Director, PCPCC

The September 16 announcement by HHS Secretary Sebelius and Vermont Governor Jim Douglas marked a new milestone for the interests championed by the Patient-Centered Primary Care Collaborative (PCPCC). The groundbreaking Medicare-Medicaid Advanced Primary Care Demonstration Initiative will enable Medicare to join Medicaid and private insurers in innovative state-based advanced primary care medical home initiatives.

It is appropriate that leadership of the PCPCC was invited to attend the announcement and participate in the robust policy and strategy discussion immediately afterwards. Our focus is to advance the patient centered medical home (PCMH), and we recognize the value of integrated initiatives that align payers and providers of every stripe behind that same objective. It is exciting to take some time to examine the events of the last three years and realize just how far the PCPCC has moved beyond simple organization as a multi-stakeholder, non-profit membership organization to become an active, working collaborative influencing the PCMH on the local, state, regional, and national levels.

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Jeanne McAllister, BSN, MS, MHA

The California Primary Care, Mental Health, and Substance Use Integration Policy Initiative

By Sandra Naylor Goodwin, PhD, MSW, President/CEO, California Institute for Mental Health

The public health crisis faced by people with serious mental illness has gained wide recognition since 2008, with data indicating that people with serious mental illnesses are dying 25 years earlier than their peers who do not have a mental illness. Sixty percent of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases; rates and complications of diabetes; and risk factors for these chronic diseases, such as smoking, obesity, and inadequate medical care.

From the primary care provider perspective, a significant number of people seeking services also need behavioral health intervention. Fifty-four percent of people with mental health issues were served in the general medical-only sector, rather than within or in combination with the specialty mental health sector. According to HRSA, among 914 federally qualified health clinics (FQHCs) with mental health programs, 1.4 million visits were provided for depression and other mood disorders. This was the third most common reason for a visit behind diabetes and hypertension.

Following a February 2008 Policy Forum that examined the importance of coordination and integration of physical and behavioral health care, mental health leaders across California began to examine ways to address the physical health care needs of their clients. The California Institute for Mental Health (CiMH), sponsor of the Forum, developed a Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative, funded by The California Endowment.

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Editor's Corner

Raymond Carter, Editor, *Medical Home News*

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



Joseph E. Scherger, MD, MPH

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Dr. Joseph Scherger is Vice President for Primary Care at Eisenhower Medical Center in Rancho Mirage, California. He is also Clinical Professor of Family & Preventive Medicine at the University of California, San Diego School of Medicine (UCSD). His main focus is on primary care education and the redesign of office practice using the tools of information technology and quality improvement.

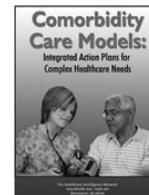
Dr. Scherger has received numerous awards, including being recognized as a "Top Doc" in San Diego for 5 consecutive years, 2004-2008; voted Outstanding Clinical Instructor at the University of California, Davis School of Medicine in 1984, 1989 and 1990; and selected Family Physician of the Year by the American Academy of Family Physicians and the California Academy of Family Physicians in 1989. In 1992, he was elected to the Institute of Medicine of the National Academy of Sciences. He has also completed 24 marathons!

Next month: Jaan E. Sidorov, MD, FACP

Medical Home Book of the Month



Comorbidity Care Models: Integrated Action Plans for Complex Healthcare Needs - This report presents emerging models of care for comorbidity, with a special focus on the needs of aging multi-morbid patients as well as those whose comorbidity encompasses physical and behavioral health conditions. Order at: <http://store.hin.com/product.asp?itemid=3892>.



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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.

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Denmark: A World Leader in the Application of Information Technology in Primary Care Improvement

By Denis Protti, Professor, Health Informatics, University of Victoria, British Columbia

The use of computer technology by primary care physicians has been a common practice in European countries for over 15 years and has been well documented. Denmark has an impressive track record with the use of individual electronic medical records (EMR) in physician offices which are all interconnected via a national communications network called MedCom.

Virtually all Danish primary care physicians and specialists use their computers to electronically send and receive clinical messages such as prescriptions, lab results, lab requests, discharge summaries, referrals, etc. Sixty standardized messages – including their “One letter solution” – have been implemented in ~100 computer systems, including 16 physician office systems, 9 hospital systems, 12 laboratory systems and 3 pharmacy systems. The national health network (MedCom) is used by over ¾ of the healthcare sector, altogether more than 5,000 different organizations. The high level of connectivity by virtually all health care providers means that most Danish primary care physicians run paper-light offices.

Most primary care in Denmark is provided by privately practicing primary care physicians, who are paid on a combined capitation and fee-for-service basis. The number and location of primary care physicians are controlled by the regions; primary care physicians’ fees and working conditions are negotiated nationally. Denmark has ~3500 primary care physicians in 2000 practices. Danish primary care physicians do not need to refer patients to all specialists; Danes are able to go directly to see ENT specialists and ophthalmologists. Danish citizens are all also free to select which hospital they would like to go to. They are also guaranteed not to wait more than two months for any treatment.

Approximately 30% of Danish primary care physicians work alone. A typical primary care physician has 1400-1500 patients up to a maximum of ~2400. A typical office visit is 8-10 minutes. Approximately 20% of primary care physicians’ income is based on the number of patients on their list while the rest is fee-for-service.

Primary care physicians are paid to be at the phone from 8-9 am every morning to take calls from their patients. Both primary care physicians and specialists are now also being paid a fee for e-mail communications with their patients. The fee for each e-mail consultation and/or e-mail (currently primarily about lab results) is twice that for telephone calls. Currently, there are some 20,000 e-mails/month exchanged by physicians and their patients. Use of e-mail was made mandatory as of the end of 2008.

Every Danish citizen has had a unique national person identification number since 1966; it is used for health and many other jurisdictions such as taxation. When first introduced, there was a reluctance to give out the number. However, with the widespread use of computer systems, starting in the ‘80s, by all private and public organizations such as schools, banks, social security, taxation, driver’s license, passports, etc., the Danish citizen accepted the use of a single identifier. The ease of use and a strong data protection law paved the way for acceptance. The many new self-service facilities such as tax submissions, home banking, pension accounts, and access to health data such as medication profiles, etc. are all based on using the unique identifier for identification.

MedCom now has 14 people on staff and an annual budget of €2 million, of which 50% covers the basic costs for running the organization. The remaining 50% is used towards specific projects, contracts, external advisers, training courses, and meetings (including paying physicians for participating). When fulfilling a contract, if the solution is implemented on time, the Regions and the software companies receive a financial bonus from MedCom.

Simplified repeat medication prescribing is of significant value to Danish physicians. Processes that used to entail having to pull charts and hand write a script now take a few seconds. Most physician office systems provide some decision support in terms of drug-drug interaction, warnings concerning pregnant patients, etc. A major focus for 2009 is to develop national standards in terms of decision support which all vendor systems will be required to introduce into their systems, and introducing a national medication record which will be updated by all hospitals, home care, and GPs. The medication record and decision support will utilize the central medication database and the MedCom VPN data network.

Before the “one letter solution” was introduced, there were hundreds of different paper-based forms for Discharge letters, Hospital Referrals, Lab results, etc. being used throughout the country. Now, there is only one “electronic form” used for all types of letters; it is used in over 5,000 health institutions with different 50 IT providers. [*Space precludes reproduction of the form in the print edition, but it is available on request. Write to editor@medicalhomenews.com – Ed.*]

The “one letter solution” defines the standards for the different paper forms in the health sector. As examples, there is just one form for all electronic discharge letters from all Danish hospitals. All specialists in all the hospitals in the country receive the same electronic referral form from primary care physicians. There is just one national electronic form used by all the X-ray departments, etc. All software system suppliers use only the one-letter solutions within their applications.

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America Awakens to the Patient Centered Medical Home...continued

A Purchaser-Provider Partnership

The PCPCC began in late 2006, when IBM and several other large national employers met and discussed the issues we all face as purchasers of health care. We were spending millions of dollars to buy episodes of care, but weren't able to buy the kind of care that prevented many costly, avoidable problems. We believed that if we could better care for employees—and help them to better care for themselves—we could avoid exacerbations that cost many more health care dollars and also take a human toll. If care were better coordinated, we knew that the outcomes could be better. So we began a conversation about how we could change the model to one in which we pay primary care providers for coordinated, integrated care.

This group of employers approached the ERISA Industry Committee (ERIC) with the idea to reach out to the American College of Physicians, the Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. These four medical provider associations were the same organizations who wrote and agreed upon the Joint Principles that define the medical home. The two essential goals of the PCPCC were (1) to formulate a joint effort to facilitate improvements in patient-clinician relations and (2) to work together, as buyers of care and providers of care, to create a more effective and efficient model of health care delivery.

Year One: Expand Reach and Educate Decision-Makers about the Model

In our first year, we focused on expanding the organization's reach to bring in more stakeholders, including providers, purchasers, consumers, and the organizations that work in their interest. We knew that the PCMH was the means to transform the delivery model, but we needed to convince a lot more people. We established a national weekly call designed to keep members informed and to connect one another with updates on our efforts and progress. The weekly call, which continues to this day, is brief—usually between 20 and 30 minutes—and is structured to follow a meaty agenda packed with research, articles, meeting dates, and data relevant to the PCMH. That first year we grew from a core of fewer than 40 employers to more than 100 signing members.

At that time, across the United States, there were already examples of the PCMH working. For example, Community Care of North Carolina has more than a decade of experience linking Medicaid and SCHIP beneficiaries to innovative practices, including development of a primary care medical home initiative that improved quality and lowered costs. One first year goal of the PCPCC was to disseminate these results along with other success stories to health care stakeholders and policy makers. The take away message was: **Success enables success**. That first year, we also started our targeted briefings on the Hill. The PCPCC developed a concrete payment reform model that we began to present to the movers and shakers who could influence legislation at the Federal level. The PCMH meant fundamental change, and we needed to ensure the right people truly understood the Joint Principles that define the model.

We also began the process of creating our first toolkit. It was appropriate to begin with a guide for employers/purchasers with tools to help them wield their purchasing power to advance the PCMH. *The Purchaser Guide to the Patient Centered Medical Home* rolled out early in year two, with health plan contract language and a model health plan request for information. The guide also offered an overview of market-based, multi-stakeholder pilots already at work across the U.S.

Year Two: Educate and Operationalize

Our second year ushered in the creation of the four PCPCC Centers, a means to maximize the strength and expertise of our many stakeholders and an avenue to put our principles to work in focused, tangible ways. The Centers are where volunteers can donate their expert knowledge to create tool kits, collect and disseminate information about topics that are relevant to stakeholders, and advance innovation that is happening in the marketplace. The four Centers and their areas of focus are:

- **Center for Multi-Stakeholder Demonstration:** Identify sites to test and evaluate the concept; share information and best practices about pilots; and serve as the connector to resources to facilitate ongoing demonstrations.
- **Center to Promote Public Payer Implementation:** Assist public payers as they implement the PCMH model.
- **Center for Health Benefit Redesign and Implementation:** Create standards and buying criteria to serve as a guide and tool for employers/purchasers to build the market demand for PCMH adoption.
- **Center for eHealth Information Adoption and Exchange:** Evaluate use and application of information technology to support and enable the development and broad adoption in private practice and among community practitioners.

In their first year, two of the four Centers produced valuable publications intended to educate distinct stakeholder audiences. The Center for Health Benefit Redesign produced the purchaser guide noted above, and the Center for Multi-Stakeholder Demonstration published the *Pilot Guide*, designed to build PCMH momentum by disseminating state-by-state sample descriptions of more than 20 key pilot initiatives.

In the second year the PCPCC leadership was more aggressive on Capitol Hill, participating in congressional testimony and arranging weekly Hill visits and briefings. We developed model language for inclusion in health reform proposals and became a key resource for congressional representatives, agency staff, the federal and state governments, and individual practices on the PCMH model. We also expanded our reach to two new key audiences—and grew to more than 240 signing members. We reached out to the insurance industry in our membership and activities. And we began a more direct relationship with state Medicaid leaders through the Joint Medicaid State Task Force and an educational partnership, including a Webinar series, with the National Academy of State Health Policy, sponsored by the Commonwealth Fund. We intentionally created a strong relationship with state Medicaid leaders, as they play a vital role in PCMH initiatives across the country.

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America Awakens to the Patient Centered Medical Home...continued

Year Three: Educate, Advocate, Demonstrate

Now completing our third year of operation, the PCPCC has grown to more than 600 signing members, with more than 770 volunteers active in the four Centers. Revenue to support the PCPCC's efforts more than doubled since January 2008 to surpass \$1 million annually. The PCPCC includes a number of large national employers, most of the major primary care physician associations, health benefit companies, trade associations, profession/affinity groups, academic centers, and health care quality improvement associations. We can also point to 27 multi-stakeholder PCMH demonstration projects in 20 states, as well as a Medicare demonstration project with eight new pilots planned (in addition to the initiative announced Sept. 16).

The PCPCC Today

Our progress today is marked by notable milestones:

- The PCPCC medical home legislative language is part of the health care reform proposals and is championed by policymakers on both sides of the aisle; and we continue to be active and well respected on the Hill.
- Our leadership presents the PCMH model regularly at national and international health care conferences.
- We disseminated purchaser-payer buying principles/standards to enable value-based purchasing of PCMH models.
- We participate actively in physician practice transformation, and we continue to evaluate pilot projects and disseminate their measurable, positive outcomes in both quality and cost savings.
- We host three annual conferences that are content-rich and well-attended.
- Our focus on the consumer has become sharper and is integrated across the work of all four Centers.

As the model progresses and gains further momentum in both the public and private sectors, the PCPCC is highly cognizant of the potential to dilute its meaning and strength as set out in the Joint Principles. The work of the four Centers offers guidance, clarity, and direction to the interrelated aspects of the PCMH as it affects buyers, payers, providers, and consumers.

In its third year the PCPCC unveiled a number of new tools to support the model and shape activity around the PCMH:

- The white paper *Meaningful Connections* is designed to spur a productive conversation about how electronic health IT can be used meaningfully, spelling out the capabilities and functionalities that are most essential to support the PCMH.
- Second, we released a set of tools to educate and engage consumers about the model, enhance access to consumer decision support tools, and advocate for enhanced caregiver/patient communication.
- The *Quick Reference Guide to Employers*, a short summary of the key points of the *Purchaser Guide*, was developed to engage more employers and to advance the conversation about the PCMH.
- *Guidelines for Multi-Stakeholder Demonstration Projects* is designed to help ensure that projects purporting to test the PCMH model remain consistent with the Joint Principles.

At the PCPCC Annual Meeting on October 22, 2009, two more work products will be unveiled: the updated Pilot Project Guide, *Proof in Practice*, and a new consumer guide, *A Collaborative Partnership: Resources to Help Consumers Thrive in the Medical Home*.

The Road Ahead

The PCPCC has grown exponentially in three short years. The achievements are tangible. We have become a primary influencer in efforts to advance the medical home. But there is still yeoman's work ahead to ensure the essential elements of the PCMH, delineated in the Joint Principles, are not diluted as the model finds its legs and leaps forward. Major focus areas in the coming months will include:

- Development of criteria for evaluation of PCMH initiatives, as well as identification of critical elements for success in practice transformation and ways to catalyze accelerated deployment of the medical home;
- Development of a more standardized reimbursement model, and enhanced engagement of employers using the PCMH's success as a springboard;
- Expansion of consumer engagement and involvement in the work of the PCPCC; and
- Enhanced activity in workforce issues, with the PCPCC serving in the role of convener and advocate for primary care providers, both legislatively and in the marketplace.

The PCPCC remains a multi-stakeholder collaborative, a place where all interested, active parties can work together to educate, advocate, and demonstrate the value of the PCMH. We are working to identify and disseminate useful tools and resources to those on the ground, the people working in collaborative partnerships that are putting the PCMH into practice across the country. Federal funding for electronic health tools, for research, and for support of active initiatives will soon become available. The PCPCC will serve as the educational and resource nexus of the PCMH movement going forward, providing the tools and guidance that stakeholders need.

We are passionate about the medical home model and its potential to transform health care delivery. Our goal is to wake up one day knowing that every American has access to a primary care provider they know is their medical home.

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Denmark: A World Leader...continued

Denmark has made a national commitment to the translation, distribution, and health-professional validation of SNOMED CT. Approximately €2.7 million has been budgeted for the translation process, which is expected to be completed by 2008. Once ready, all vendors will be expected to imbed the SNOMED CT nomenclature into their systems. There is at the moment no contract about the timing of when this process should be finalized. It is noteworthy that the new international SNOMED standards body is headquartered in Copenhagen.

The Danish national health portal was created in 2005 so as to provide information about the Danish National Health Service to its citizens and patients. It is also was the beginning of a unified hub for electronic communication between patients and the Health Service. The new health portal permits both providers and patients to access laboratory results online via the Internet. Additional services available on the portal include: access to medication profiles, waiting list information, online scheduling of primary care physician appointments, e-mail contact to primary care physicians, and on-line renewal of prescriptions by patients.

The impact of information technology, particularly in primary care, though difficult to show empirically, must be significant. How could the number of visits to Danish primary care physicians be increasing over the past 10 years while the number of practicing primary care physicians has been decreasing? And there is little evidence to suggest that Danish primary care physicians feel they are working too many hours and/or are burning out.

Perhaps innovations such as payment to physicians for phone call visits, with designated call-in times, has helped as well as e-mail consultations. Gaining an hour a day through automation processes no doubt has also helped. Demographics and the demands of different age/gender groups on the health care system may also play a role.

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The California Integrated Policy Initiative ...continued

To lead this Initiative (IPI), CiMH was joined by the California Primary Care Association and the Integrated Behavioral Health Project. The final IPI Initiative report has been released and can be found on the CiMH website, www.cimh.org.

As a time-limited project, developed to address the pressing need for improved linkages between the physical, mental, and substance use healthcare systems serving California's Safety Net Population, the IPI goals were to:

1. Develop a set of policy recommendations enhancing the interface between physical, mental, and substance use care.
2. Advance these recommendations through a report to local and state policy makers identifying changes in law, regulation, and practice to support integration of mental health, primary care, and substance use services.
3. Accelerate the systems integration needed to enhance the health outcomes of underserved populations and to promote efficiencies across the safety net systems.

The IPI created a series of dialogues among representatives from these three health care systems. The process examined researched models and built on the substantial body of work already underway in California. The IPI was also informed by the national healthcare reform discussion—especially the concept of the Medical Home. California providers' experience with barriers to implementation guided the development of recommendations for state and local actions to improve integration in the safety net system—even in light of the State's continuing fiscal crisis. The report's ideas and recommendations offer a bridge from how the physical, mental, and substance use health care systems operate in silos in 2009 to how they might operate by 2014. While seeking bridges, it is acknowledged that California's mental health and substance use agencies are responsible for providing systems of care that operate as specialties—much as there are specialty services in the physical health care arena. Integration as envisioned in the IPI enhances, but does not replace, these specialty systems of care, which include comprehensive treatment and community support services critical for individuals with the most serious mental health and substance use needs. Safety net providers will face continued challenges in working collaboratively in this new environment, and the IPI recommendations are intended to support them in successful collaboration.

The vision of the Integrated Policy Initiative is this: that overall health and wellness is embraced as a shared community responsibility. To achieve this vision, health care services for the whole person (physical, mental, and substance use care) must be seamlessly integrated, planned for, and provided through collaboration at every level, as well as coordinated with the supportive capacities within each community. Ten principles are articulated as the foundation for that collaborative activity. These principles introduce the expectation that planning and implementation ensure that:

- Each individual has a person-centered health care home, which provides mental health (MH) and substance use (SU) services in the primary care setting or primary care services in the MH/SU setting.
- Each community has established a Collaborative Care MH/SU Continuum (the IPI Continuum), as described below. The community dialogue to establish the Continuum should result in mechanisms for stepped MH/SU health care back and forth across the Continuum, mechanisms to address the range of physical health risk/complexity/acuity needs of the population, and collaborative links across health care systems, community services, and resources.
- Measurement is aligned to support the IPI Continuum, with quality Improvement and implementation of proven models, as well as evaluation of emerging models, with accountability, transparency, and measures matched to the levels of the Continuum.

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The California Integrated Policy Initiative ...continued

The IPI final report provides recommendations regarding delivery system design, financing, regulations, workforce, and healthcare information technology. These recommendations are available in the report. However, this paper focuses on the IPI Continuum as a framework for service development and the creation of person-centered health care homes.

IPI Continuum: The IPI Continuum is a service development framework that identifies population needs across levels of MH/SU risk/complexity/acuity and assigns provider responsibilities within a community for delivering those services. This framework incorporates ideas from several national models for improving primary care and the integration of MH/SU services, as described in the following discussion.

The National Council for Community Behavioral Healthcare's **Four Quadrant (4Q) Model**ⁱ is a planning tool for addressing the needs of the population in each community (system planning must be population-based, while service planning must be person-centered). The 4Q Model indicates that there are levels of care in the behavioral health, substance use, and physical healthcare systems (from primary care to specialty providers, hospitals, and emergency rooms) and that the integrated care model needs to be articulated at all these levels.

The 4Q model provides a structure for a community to plan across the physical, mental, and substance use health care systems; the IPI Continuum provides detail for thinking about four levels of MH/SU services while not attempting to also articulate the levels of physical healthcare (the horizontal axis of the 4Q model).

The primary care world is also involved in a whole range of concurrent conversations regarding the horizontal axis, focused on improving access and services for people with high physical healthcare needs.

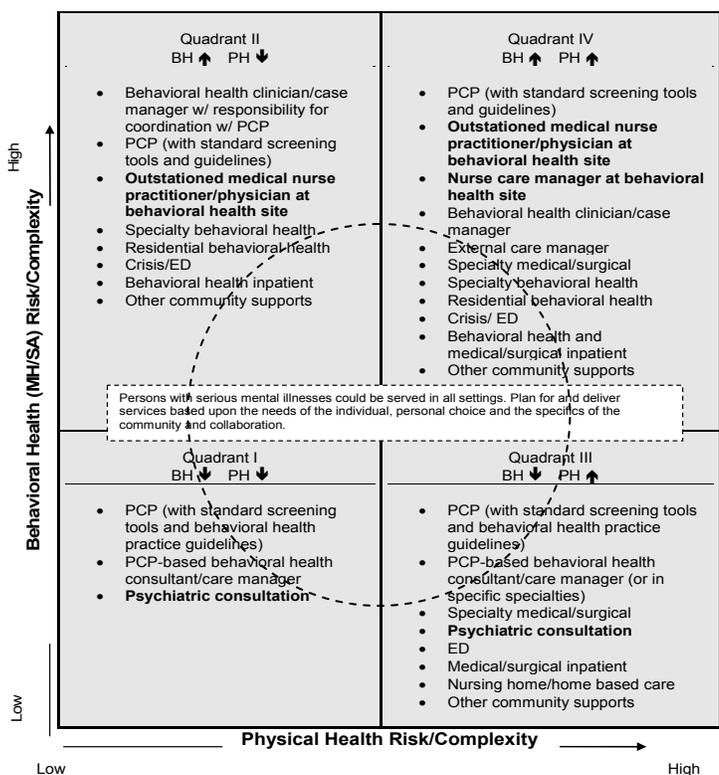
Access to specialty medical/surgical services continues to be difficult for safety net providers and the populations they serve; there are other initiatives underway in California specific to this set of relationshipsⁱⁱ.

The IPI Continuum, therefore, focuses on MH/SU risk and further articulates levels of MH/SU care, derived from an integration model developed at **Intermountain Healthcare**ⁱⁱⁱ. The IPI Continuum uses the Intermountain idea of defining levels of care and expands to include the needs of individuals with severe and persistent mental illnesses, describing the characteristics of the populations in each level and the types of MH/SU services that should be available to them. Use of the IPI Continuum is intended to help communities clarify provider roles, especially in relationship to the area in which both physical and MH/SU are similarly complex—where decisions about which services are provided in which organizations by which practitioners can be confounding.

Another model that is a foundation for the IPI Continuum is the Patient-Centered Medical Home. A proposed name change to **Person-Centered Healthcare Home**ⁱ signals that MH/SU services are a central part of health care and that health care includes using these services to support a person's capacity to set goals for improved self-management. The Person-Centered Healthcare Home is envisioned as bidirectional: provide MH/SU services in primary care settings and provide primary care services in MH/SU settings. Behavioral health is the appropriate Healthcare Home for individuals with severe/complex behavioral health issues.

The **Chronic Care Model**^{iv}, developed to improve primary care for people with chronic health conditions, such as diabetes or cardiovascular disease, underpins the Patient-Centered Medical Home concept. The model expands the view beyond the clinical setting, incorporating self-management and the resources of family/neighborhood/community. The Chronic Care Model has recently been adapted for use in MH improvement planning^v in California, as shown in the diagram below, in which the community element has been further clarified to add **Social Inclusion & Opportunity**. Future evolution of the model in California will need to incorporate SU services as well.

The Four Quadrant Clinical Integration Model



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The California Integrated Policy Initiative ..continued

Chronic Care Model Elements^{iv} include:

1. *“Health System: Create a culture, organization, mechanisms that promote safe, high quality care*
2. *Delivery System Design: Assure delivery of effective, efficient clinical care, self-management support*
3. *Decision Support: Promote clinical care consistent with scientific evidence and patient preferences*
4. *Clinical Information Systems: Organize patient/ population data to facilitate efficient and effective care*
5. *Self-Management Support: Empower and prepare patients to manage their health and health care*
6. *The Community: Mobilize community resources to meet needs of patients”*



The IPI Continuum: A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population All Ages (children, youth, adults, older adults)				
	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Characteristics of population w/ MH/SU needs to be served				
Estimated population needing MH/SU Services				
Healthcare Home Services to be made available				
Optimal MH/SU Services for each MH/SU level				
Examples of evidence-based practice & examples of process, capacity, and/or outcome measures				

The **IPI Continuum** incorporates all of these ideas and focuses on four stepped levels of MH/SU care, as shown on the chart above. In order to plan for and implement the IPI Continuum, there is significant detailed work to be done at the state and local level. The work includes ensuring that:

1. A population-based systematic approach is created that identifies and serves those who will benefit from collaborative, integrated services, meets the needs of those seeking or in need of services, and reduces redundant services.
2. Prevention and early intervention services are available across the entire IPI Continuum.
3. MH/SU services collaborate effectively and co-occurring disorders competency is a core value in implementation.
4. A clear clinical process and set of collaborative workflows are established in each clinical site. Co-located care is necessary but not sufficient to achieve collaborative care.
5. Standardized screening and assessment/evaluation methods are used consistently across systems and settings and guide stepped care.
6. Bi-directional service capacity provides MH/SU services in primary care settings and primary care services in MH/SU settings. “No wrong door” ensures easy access to stepped care, including:
 - Capacity to respond wherever a person seeks services as well as connection to other points of origin (such as criminal justice).
 - Capacity to respond as a person’s needs change over time, with mechanisms for individuals to step back and forth to the right level of Continuum services.
7. The resources of the community are organized to support individuals across the IPI Continuum. The Person-Centered Healthcare Home is located in a community, and consumers/families/friends and a broad sector of the community are actively involved in developing the local IPI Continuum.
8. The IPI Continuum is adopted by physical, mental, and substance use healthcare providers. The set of Continuum services is consistently available statewide; however, the organizational setting of services will vary depending on the local community’s agreements regarding resources and capacities to build the IPI Continuum.
9. The IPI Continuum is implemented so that lead roles at points on the Continuum are clear and agreed upon by all providers in the community, through protocols or other mechanisms.
10. Information technology and registries are used to maximize service planning and bring together services into a single plan for achieving an individual’s health and wellness.
11. There is systematic attention to workforce development to achieve improved system performance and the need for cultural and linguistic competence, stigma reduction and collaborative care skill development.
12. Finance, policy, and regulation are aligned to support the IPI Continuum.

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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: "Will the boundaries between what is 'primary' and what is 'specialty' care blur as we get better at patient-centeredness, with a PCP doing things that used to be referred out to specialists and a chronic care specialist being a 'primary' care coordinator?"

"The message in *The Innovator's Prescription* [co-authored by Clayton M. Christensen, Jerome H. Grossman, MD, and Dr. Hwang – Ed.] was simply that the responsibilities of everyone in the medical workforce, from specialists to generalists to nurses to patients, must change over time in order to build a rational, cost-effective system. Without a flexible workforce, our business models of care delivery fail to keep up with the changes and potential benefits of medical technology. If we can overcome the widespread guild mentality among physicians and overturn the outdated regulations that have come to protect providers more than they do their patients, then we will absolutely see tomorrow's generalists doing more of what we currently rely on specialists to do. Just as we view nurse practitioners today as "mid-level" providers, tomorrow's generalists will essentially be mid-level specialists. The need for specialty care won't disappear, as we will always need experts in the field to explore new scientific frontiers, but the line between specialists and generalists will definitely blur.

When it comes to chronic care (and wellness care, for that matter), I believe the role of care coordinator can be served in more than one way. Today, we rely on primary care physicians to manage this role, and even though several physician groups are lobbying heavily to collect some much-deserved compensation for that work, I feel that it's not essential for all patients to have a physician-directed medical home. Just as generalists are disrupting specialists, we may see nurses and patients armed with software and online tools begin to supplant physician-coordinated care. Without a doubt, care coordination is critically important to delivering quality health care, but patients deserve to choose the method of care coordination that best fits their individual needs. If we can accept that that may or may not include a physician, then we can truly start to call it a patient-centered medical home."



Jason Hwang, MD, MBA

Co- Founder and Executive Director of Healthcare, Innosight Institute
Co-Author, *The Innovator's Prescription*
Cambridge, MA

"All questions about the medical home have to be predicated on the assumption that the primary care practice is truly comprehensive - that they provide very comprehensive, high quality, longitudinal, relationship-based care to their patients focused on both their mental and physical health. I believe that the instances where a specialist will or should play this role are quite limited, and that as a health policy, we should keep specialists sharply focused on only providing the complex specialty care that they are uniquely qualified to provide. If that is our focus, then rarely should a specialist be the medical home. Some exceptions might be patients with end stage renal disease or advanced cancer. However, even in these instances, if the specialist is going to take total responsibility for the patient, then he or she has to accept dealing with all of the patient's needs, including preventive where appropriate, mental health, and the broad array of physical health needs. I simply don't think that it is a good use of a specialist's skills to do this as a matter of routine, with few exceptions.

We have a perception that complex chronic care is hard and that conditions such as advanced congestive heart failure are actually hard to manage. I don't agree with this. While such patients may require a good amount of coordination, there are rarely issues in their care that cannot or should not be manageable by a well-trained, comprehensive primary care physician and practice. I do believe that it is a challenge to many in primary care today to create such comprehensive practices and to express it fully in the services they provide to their patients, such as care management. On the other hand, there are a great many primary care practices that do have that desire and those skills, although they frequently lack the resources to provide those services.

I believe that it is critical to understand this dynamic, because the payment system should be set up to foster just this system design – to encourage truly comprehensive, high performing primary care and to allow specialists to focus sharply on their unique skills. Specialists should be continually encouraged to move patients back to primary care for ongoing management, and they should be incented to participate in coordination of care activities with their comprehensive primary care colleagues."



Charles M. Kilo, MD, MPH

Chief Executive Officer, GreenField Health and The GreenField Group,
Fellow, Institute for Healthcare Improvement
Portland, OR

Thought Leader's Corner ...continued

"I partially agree with Clayton Christensen's thesis that PCPs will gradually disrupt specialists (using 'intuitive medicine' for problem diagnoses), nurse practitioners will disrupt the routine components of primary care (using rules-based, limited scope 'precision medicine'), and nurse networks (health management vendors or online communities) will disrupt primary care for chronic condition patients needing strong behavioral support. In addition, I expect many patients with chronic conditions to assume the role of their own 'primary care provider' with tools and technologies that empower them to take charge of their health in ways not feasible previously. I disagree with Christensen's dismissing of the medical home model as trying to be 'all things to all people' and conflating business models that should be separated for the sake of disruptive innovation. Many years of primary care research (in the U.S. and abroad) have substantiated the efficiency and quality advantages of most patients getting most of their care from primary care physicians most of the time. Unfortunately, that is far from what we have now in this country; hence the need for health care reform.

In time, I envision a hybrid 'virtual medical home' model will emerge that allows PCPs to devote more of their time to the intuitive medicine tasks, enables ancillary staff supported by decision support systems to oversee the rules-based precision medicine, and networked remote nurses to handle the chronic conditions and facilitate social networking for peer support, home monitoring, and rapid diagnostics. Some of these resources will reside within a given provider practice, while other elements will be accessible remotely through home devices and the Internet. All of this care will be integrated and orchestrated via a unified longitudinal care plan represented in a Personal Health Record that has interoperable information exchange with provider EHR systems."

**Gordon K. Norman, MD, MBA**

Executive Vice President, Science and Innovation, Alere,
Chair, Board of Directors, DMAA: The Care Continuum Alliance
Reno, NV

"In cardiology, the lines between specialty and primary care already overlap. Currently, patients see primary care physicians for management of their cardiovascular risk factors, such as hypertension and high cholesterol. If the patient develops a serious heart condition, such as angina, ventricular arrhythmia, heart failure, or suffers an acute myocardial infarction, he or she transitions to care under a cardiologist, who takes on managing both the heart disease and often many of the other conditions previously managed by the primary care physician. In this way, the cardiologist already is much like a primary care coordinator. Primary care and specialty need to work as partners in the care of their patients.

I predict with a movement toward patient-centeredness what we will see is not a blurring of roles, but the improved use of team-based care. Care that is provided by a team of practitioners, including primary care physicians, specialists and mid-level providers, will result in the highest quality of care possible, and at the most appropriate site of care, as long as the team is committed to coordination and communication. Through this coordination and communication, hassles will be decreased for patients and doctors. Meanwhile, the strengths of each type of physician and team professional are harnessed. This kind of real or virtual integration will improve care more than any "blurring" of roles between primary and specialty care."

**Jack Lewin MD**

President
American College of Cardiology
Washington, DC

The California Integrated Policy Initiative ...continued

The IPI Continuum is intended to support further community-level and statewide discussions of integrated, collaborative health care. It is also intended to be a learning tool and developing document as California providers work together to define and implement collaborative, integrated healthcare. We are eager to take up the challenge.

Sandra Naylor Goodwin, PhD, MSW is President/CEO of the California Institute for Mental Health in Sacramento. She can be reached at sgoodwin@cimh.org.

References:

- ⁱ Mauer, B. Behavioral health/primary care integration and the healthcare home. National Council for Community Behavioral Healthcare, 2009. <http://www.thenationalcouncil.org/>
- ⁱⁱ For a series of reports on safety net specialty referrals, along with a review of web based referral systems, see <http://www.chcf.org/topics/view.cfm?itemID=133947>
- ⁱⁱⁱ <http://intermountainhealthcare.org/Pages/home.aspx>
- ^{iv} <http://www.improvingchroniccare.org>
- ^v The revised Care Model was developed by CiMH as part of the California Mental Health Care Management Program, CalMEND. <http://www.calmend.org/>
- ^{vi} *Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders: Transforming the Mental Health System Through integration.* MHSOAC, 11/10/08.

INDUSTRY NEWS



CIGNA Launches Texas Medical Home Pilot

CIGNA has just launched a pilot medical home project with Medical Clinic of North Texas (MCNT), a physician organization headquartered in the Dallas-Fort Worth area. MCNT has with more than 120 board-certified primary care physicians and specialists in 43 clinics in 18 Texas counties. According to CIGNA, this is the first commercially sponsored medical home type program in Texas that involves a multi-site medical practice and a single private payer. CIGNA will provide upfront funding to establish a process of care coordination led by a registered nurse, working with a team of MCNT professionals and CIGNA data and clinical tools. Currently, more than 10,000 individuals covered by a CIGNA health plan can receive care from MCNT primary care physicians. The project, which began September 1, will be ongoing and will be evaluated after 12 months. More info at: http://newsroom.cigna.com/article_display.cfm?article_id=1093



Demark Expands Telehealth

As a complement to this month's article, the Danish government last month announced that by 2012 it will have implemented nationally a videoconferencing system that allows non-Danish speaking patients to communicate with hospital personnel via a call center staffed by multilingual operators. On the same national timetable is a second project to allow Danish patients with COPD to be monitored remotely by sending reports and vital signs from home to nurse care managers.



AHRQ Highlights PCMH, Announces eRx Study

The featured topic for the September 6 AHRQ weekly Innovative Exchange series was the Patient-Centered Medical Home, with commentary from AHRQ Director Dr. Carolyn Clancy, information on two innovative projects (a mobile clinic in Phoenix for homeless and at-risk youth and CareOregon, a Medicaid managed care plan), and an op ed from Gregory Pawlson, MD, MPH, FACP at NCQA. Go to: http://www.innovations.ahrq.gov/whatsnewArchive_issue.aspx?id=60

As reported in *Healthcare IT News* on September 2, AHRQ also announced last month that it will be surveying physician practices to determine what percentage have implemented e-prescribing systems. The Center for Studying Health System Change will conduct the study, which will involve interviews with physicians, IT administrators, pharmacists, and other staff at 110 physician organizations across the country over the next two years, under an existing AHRQ contract.

The Physicians' Foundation

New Physicians' Foundation Report Released

On September 10 the Physicians Foundation sent to the President and the Congress a special report it commissioned on socioeconomic determinants of health care access, quality, and cost. The report laid out six goals for health care reform: (1) Undertake a major expansion of the physician workforce, (2) Build the workforce of midlevel practitioners, (3) Build a broad system of front-line primary care and public health services, (4) emphasize physician training in areas where physicians are uniquely capable of providing care and reshape the career paths of generalist physicians to take advantage of their capacity to manage chronic illness and multisystem diseases, (5) Shorten the length of medical education from premed through residency, and realign medical education with the realities of clinical practice, and (6) Equip physicians with better IT and access to medical effectiveness research, recognize the vast differences in socioeconomic characteristics among patients, create a Medicare reimbursement formula that acknowledges that physician services will continue to grow in quantity and complexity, and recognize that, ultimately, physician autonomy is the friend of quality. The report is at <http://www.physiciansfoundations.org>.



New Hospital Care Collaborative Formed

Six national health care professional organizations have formed a Hospital Care Collaborative to promote team-based care in the hospital setting and to identify and promote best practices. The six are the American Association of Critical Care Nurses, American Association for Respiratory Care, American Society of Health-System Pharmacists, Case Manager Society of America, the Society for Social Work Leadership in Health Care, and Society of Hospital Medicine. The groups adopted a set of 12 principles to guide their work, among them "The HCC believes in patient-centered care, rather than provider-centered care, and that the healthcare team members should involve the patient/family/caregiver in developing care plans and goals of care." The full set of principles is on the American Society of Health-System Pharmacists web site at www.ashp.org.



New ITIF Report Confirms Woeful US IT Use

A September report by ITIF's David Castro notes that use of EHRs by primary care physicians in Sweden is 100%, Denmark 95%, and U.S. 28%. Enough said. <http://www.itif.org/files/2009-leadership-healthit.pdf>



Catching Up With ...

Jeanne McAllister, BSN, MS, MHA

Jeanne McAllister is Director and Co-Founder of the Center for Medical Home Improvement (CMHI) of the Crotched Mountain Foundation in Greenfield, NH – www.medicalhomeimprovement.org -- which serves individuals with disabilities and their families. CMHI promotes high quality primary care in the medical home and supports primary care practices across New England and the U.S. Ms. McAllister has been engaged in research, practice improvement, teaching, advocacy, and project management for medical homes serving children, youth, and adults since the early 1990's. She is widely published and widely respected. She talks about her work and reflects on what a small world this is.

Jeanne Walker McAllister, BSN, MS, MHA

- Director, Center for Medical Home Improvement (CMHI), Crotched Mountain Foundation, Greenfield, NH (2004 – Present)
- Adjunct Associate Professor of Pediatrics & Psychiatry, Dartmouth Medical School (2007 – Present)
- Lead consultant, American Academy of Pediatrics National Center for Medical Home Initiatives; Co-Principal Investigator, grant from The Commonwealth Fund to the University of Connecticut on care coordination in high performance pediatric care systems (2006 – Present)
- Hood Center for Children and Families, Children's Hospital at Dartmouth Hitchcock Medical Center, Lebanon, NH – Research and project management positions leading to establishing the Center for Medical Home Improvement (1993 – 2004)
- Bachelor of Science in Nursing (BSN), University of Vermont; Masters of Health Science Education (MS), Health Professions Education, University of Pennsylvania; Masters of Health Administration (MHA), School of Health and Human Services, University of New Hampshire.

Medical Home News: *You have been about this “medical home” stuff probably longer than anyone. Has it matured and spread as rapidly as you would like over the past 10 years and more?*

Jeanne McAllister: Yes and no. Recently, medical home initiatives have spread far more quickly than many of us dreamt possible. Yet at times I worry that the viral “spread” of the medical home may risk running “thin” and lacking fidelity to the meaning of the model. There is a rush to be included in pilots, to be “recognized”. The application process is extensive and, once achieved, clinicians and staff breathe a sigh of relief, tempted to declare their medical home evolution complete. But a continuous, energizing, and transformative team process with quality improvement and testing of care innovations is now crucial. Such emphasis, coupled with patient and family-centeredness, is what will result in efficient and effective health care.

Medical Home News: *There is a very specific set of characteristics that define a “patient-centered medical home.” Does it trouble you at all when the term “medical home” is loosely applied to mean simply a stable primary care assignment?*

Jeanne McAllister: The characteristics are helpful, but yes it does. The medical home was born in pediatrics, with a re-emphasis on the family/family-centered care. Pediatric medical homes have consistently acknowledged that a medical home does not mean simply having a primary care provider's name on your insurance card. Leaders are cautioning that medical home momentum has occurred before the evidence fully supporting the model is in and that failure to show cost savings will dilute its impact. The latter is true of course. However, we have evidence that a relationship with a consistent provider and team over time, in a primary partnership relationship, improves both health and cost outcomes. I am concerned that unless a multipronged investment in primary care occurs, erosion or degradation of the true meaning of the “medical home” could actually contribute to a pervasive cynicism about our health care system.

Medical Home News: *How well do you think we are doing as a nation in meeting the health care needs of children and adolescents with special needs? What's the most important change you would make if you were in charge?*

Jeanne McAllister: This is difficult to answer briefly. We have made incredible progress in our knowledge and treatment of various chronic conditions, and yet it seems that our systems fall further behind. Child health and education systems are a patchwork quilt developed reactively over multiple years, with professionals struggling to meet families' needs in the face of deep programmatic cuts. The change I would make would be to establish one clear voice for children, such as a state level children's cabinet or coalition charged with redesigning our systems to create truly integrated health and educational efforts. This would include full representation of youth and families, who must be equal partners in the system re-design process.

Medical Home News: *The Administration is readying the new national demonstration program for medical homes serving the Medicare population. Are there differences in the way a medical home for children needs to operate than one for relatively healthy adults or for the very elderly with multiple chronic conditions?*

Jeanne McAllister: There are more similarities than differences. Many resources and tools CMHI has developed for children have been adapted for adults with chronic conditions or the frail elderly. Families must always be a part of the equation particularly for children/youth. Opportunities to help parents raise healthy, well children are significant; in this way we can have an impact upon the health and wellness of entire extended families. The primary care medical home for all ages, across the lifespan, is perhaps a better concept than pediatric versus adult. A true medical home is good for you at any age.

Medical Home News: *You did your master's on allied health professions. What should we be teaching students today?*

Jeanne McAllister: Team skills with opportunities for health care professionals to learn in teams (rather than separately). Patient advocacy with patient/family-driven improvement is also needed. Care coordination, addressing medical, social, developmental, behavioral, educational, and financial needs must be included. Ideally educational experiences would help learners to walk in their patients' shoes, follow them throughout episodes of care, from hospital to home to school and work, through their navigation of the health care and payment systems. Traditional learning, focused primarily on face-to-face encounters in discrete hospital or clinic visits, is simply not sufficient preparation for today's professionals.

Medical Home News: *Finally, tell us something about yourself that no one would be likely to know.*

Jeanne McAllister: I grew up in a small suburb of Cincinnati. One of my favorite playmates as a young girl was Ellen Gilligan. She and I used to sneak into her older sister Kathy's room to play with her dolls and other toys. This at times led to some childhood spats! That “Kathy” is Kathleen Gilligan Sebelius, now Secretary of Health and Human Services, who just announced a major medical home initiative involving Medicare and existing state multi-stakeholder projects. Small world!