Demo Helps Define What Makes a Medical Home

BY DENISE NAPOLI
Associate Editor

If patient-centered medical homes are to be the new standard in care, fee-for-service practices will have to convert to the new model.

Dr. Richard Baron and his four-physician practice in Philadelphia are part of a growing contingent devoted to finding out exactly what that will entail.

"The thinking behind the patient-centered medical home is that if you fund primary care more robustly, you will see decreased costs and increased quality," Dr. Baron said. "But nobody really knows what particular aspects of primary care are the ones that you should be looking for."

To try to answer that question, Dr. Baron and his practice, Greenhouse Internists PC, helped to plan and are participating in the Southeastern Pennsylvania Chronic Care Initiative, a medical home demonstration project that is a collaboration of the Pennsylvania Chronic Care Management, Reimbursement, and Cost Reduction Commission and the Patient-Centered Primary Care Collaborative.

"The major interest we had for participating in the pilot was the prospect of increased reimbursement for services that, in our practice, we were already providing—plus some that we would like to be providing but could ill afford to," he said in an interview.

Greenhouse Internists has made several changes to conform to the 90-page medical home guideline from the National Committee for Quality Assurance (NCQA), which assigns points in each of 10 categories to stratify practices into tier I (minimally compliant), tier II, or tier III medical homes. The measures include things like whether a practice has established written standards for patient communication, whether it uses data to show if standards for patient access and communication are met, and whether a prac-

tice uses charting tools to organize clinical information—activities that don't count for much in the current reimbursement system, but that are crucial to the establishment of a medical home.

The first change that Dr. Baron's practice made, even before enrolling in the demonstration project, was the installation of an electronic medical records system. "It cost us $140,000 or $160,000 for a four-doctor group, and we didn't see any increased reimbursement from anybody for having made that investment." But under the pilot, "there are points we get from the way we use the EMR that allow us somewhat to recoup the investment," said Dr. Baron, who is also chair of the American Board of Internal Medicine.

For conversations aimed at patient education to be reimbursed as part of an integrated medical home, they must be documented in the EMR system.

Another change was the hiring of a "health educator" to develop systems to fulfill the NCQA guidelines that require patient involvement and education, Dr. Baron said. For example, the health educator has created action plans that remind the physicians to have conversations with diabetes patients about managing blood sugar and weight loss.

"Most of us in primary care know we're supposed to have those conversations, but most of us are so desperate to get through the day that … we don't. It's a workflow issue," he said. And for those conversations to be reimbursed as part of an integrated medical home, they must be documented in the EMR system.

Greenhouse Internists is also increasing both the number of medical assistants and the number of non–clinically trained staff. "One of the things that you get when you start using the EMR is the ability to look [through the records] for the patients with poorly controlled diabetes whom you haven't seen in 6 months," Dr. Baron said. "But once we've done that, it isn't obvious who is in the office to pick up the phone and call them." In a traditional practice, the job would probably fall to the physician. "Doctors get into a pretty toxic spiral. … There isn't anyone to do it, so they do it themselves, and that's the worst answer, because we cost more than anybody."

Non–clinically trained or nonphysician office staff are "underutilized" in primary care practices, he said. By hiring more nonclinical staff, Greenhouse can relieve physicians of tasks they would otherwise have to do.

In the meantime, Dr. Baron said he knows that the medical home movement is still only in the early stages.

"There's a lot of skepticism in the health care community about whether the patient-centered medical home is a flash in the pan. Is it going to go away?" he asked. And while practices like his participate in demonstrations, "the sad reality is that in a fee-for-service system, [non–visit-based care] takes the doctors off the fee-for-service treadmill, which is how they create income."

Nevertheless, Dr. Baron is excited to be participating in the demonstration. "On the one hand, it's extra work for a group of people who are already pretty busy. But on the other hand, there's a sense of wonderful opportunity," he said. "For us, this pilot is a way to recoup investments that we've already made, because we believe in a non–visit-based model of care." ■

Medical Home Demo Seeks Four Coordinating Centers

BY MARY ELLEN SCHNEIDER
New York Bureau

The Commonwealth Fund is gearing up to turn 50 safety net clinics into models of the patient-centered medical home.

The demonstration project, called the Safety Net Medical Home Initiative, will run for 5 years with the goal of creating an implementation plan that can be replicated at practices and clinics across the country.

The Commonwealth Fund is funding the project, which will be run by the Seattle-based quality improvement organization Qualis Health, along with the MacColl Institute for Healthcare Innovation. In the first year of the project, the Commonwealth Fund is providing nearly $700,000; total 5-year funding for expected to reach $6.7 million.

Qualis Health and the MacColl Institute for Healthcare Innovation will offer technical assistance to participating clinics on aspects of the patient-centered medical home including timely access to primary care services, enhanced communication, and team-based care.

The Commonwealth Fund and its partners currently are seeking applications for four regional coordinating centers.

The staff at these four centers would provide assistance to 12-15 local safety net clinics as well as promote the concept of the patient-centered medical home with state Medicaid officials.

Eligible entities include community clinic consortia, state primary care associations, regional health care alliances, community hospitals with outpatient services, public health departments, state Medicaid agencies, and Medicaid managed care plans, among others.

Applications, due by Nov. 3, can be downloaded at http://qhmedicalhome.org/safety-net/index.cfm.

Privacy Should Be Main Criterion For Personal Health Records

Privacy should be the top priority when developing certification criteria for personal health records, a task force created by the Certification Commission for Healthcare Information Technology has recommended.

Adequate security and interoperability also must be included in certification efforts, according to the task force.

The CCHIT will use these recommendations as it prepares to begin certifying personal health records (PHRs) next summer.

Since the PHR field is still "rapidly evolving," the task force said that certification requirements should not be so prescriptive that they interfere with the progress of the technology.

The task force recommended that the voluntary certification process should apply to any products or services that collect, receive, store, or use health information provided by consumers. Certification should also apply to products or services that transmit or disclose to a third party any personal health information.

This would allow the CCHIT to offer certification to a range of products and applications, from those that offer a PHR application and connectivity as an accessory to an electronic medical record (EMR), to stand-alone PHRs.

CCHIT hopes that, just as it did in the EMR field, certification will create a floor of functionality, security, and interoperability, said Dr. Paul Tang, cochair of the PHR Advisory Task Force and vice president and chief medical information officer for the Palo Alto (Calif.) Medical Foundation.

The task force called for requirements to maintain privacy in monitoring and enforcement, and for consumer protection that would allow patients to remove their data if certification is revoked. The group also recommended that standards-based criteria be developed that would require PHRs to send and receive data from as many potential data sources as possible, including ambulatory EMRs, hospital EMRs, labs, and networks.

If done right, certification would have significant benefits for both physicians and patients, Dr. Tang said. A PHR could provide physicians with better access to secure, authenticated data that could help them make decisions, while patients would have more control over their own care, he said.

—Mary Ellen Schneider