Patient-Centered Medical Home
Implementation Resource Tool Kit

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Foreword

The Louisiana Health Care Quality Forum (Quality Forum) is pleased to provide this Implementation Resource Tool Kit for the patient-centered medical home. The Quality Forum’s mission is to lead evidence-based, collaborative initiatives to improve the health of the people of Louisiana. The work of the Medical Home committee to promote the adoption of the medical home system of care is of primary importance in accomplishing this mission. In March of 2008, the Quality Forum’s Board of Directors voted unanimously to endorse the Joint Principles of a Patient Centered Medical Home and the National Committee for Quality Assurance (NCQA) Guidelines for the Patient-Centered Medical Home, becoming the first statewide multi-stakeholder collaborative to do so. With this action, the Quality Forum called for commitment by providers and systems statewide, both public and private, to lead the redesign of delivery systems to support patient centered, coordinated care for the improvement in quality and health outcomes.

The materials in this tool kit are meant to be practical supports for those in the process of, or contemplating implementation of the medical home model of care. The tool kit was developed to help those who are at the grass roots level with understanding what a medical home is, how it is implemented, and mechanisms for action. Through the referenced websites and links contained in the tool, we have provided a brief view into some of the more successful medical home demonstrations around the country. The Quality Forum’s Medical Home Committee is working with several service delivery redesign projects in Louisiana that illustrate various stages of development of the medical home model. We hope this tool kit will be useful in bring to light their commonality with NCQA standards, and highlight best practices in use.

This Implementation Resource Tool Kit is the result of a collaboration of many. The Louisiana Health Care Quality Forum was born of stakeholder action to move forward the recommendations of the Louisiana Health Care Redesign Collaborative for rebuilding the Region I health care delivery system after hurricanes Katrina and Rita. Following the Collaborative, a group of forty organizations worked over nine months to define the purpose, roles, responsibilities and composition of the Quality Forum. As a result, the Quality Forum’s 12 member volunteer Board of Directors is composed of representatives from major health care purchasers, health plans, providers, and consumer advocacy groups. Dozens of other stakeholders serve on the Quality Forum committees and stakeholder advisory workgroups.

The Quality Forum established the Medical Home committee, consisting of researchers, providers, administrators, policy makers, consumers and stakeholder advisors and charged it to “convene the state’s major healthcare stakeholders for the purpose of developing and accelerating the adoption of standard components and criteria for the delivery of health care services via the patient-centered medical home system of care.” Developing an Implementation Resource Tool Kit is an important step to achieve our purpose to make the medical home model the standard in the State of Louisiana. This Implementation Resource Tool Kit for the patient-centered medical home is a structured resource repository of information for intended for use by primary care practices in implementing the patient-centered medical home. We looked to many experts in the health care fields to help shape and
mold our vision of the Implementation Resource Tool Kit. Many websites are listed in the Resource Links section.

As the patient-centered medical home model is implemented throughout the State of Louisiana, we hope to continue the development of additional Tool Kits. We consider this a first edition. Assessments and lessons learned from projects utilizing this tool kit will tell us how to make improvements in future editions. We hope this Implementation Resource Tool Kit will be helpful to communities across the state. We invite you to explore the content, and get involved. You can access the Quality Forum website at www.lhcqf.org to read the latest recommendations and leave your comments. As Louisianans, we all have a stake in our health systems. The Quality Forum endeavors to make resources available, such as this Implementation Resource Tool Kit, to primary care practices so that they can provide the most effective patient-centered services possible for all Louisianans.
Introduction

We are pleased to present the Louisiana Health Care Quality Forum’s (Quality Forum’s) Medical Home Committee’s Implementation Resource Tool Kit. The Quality Forum’s Medical Home Committee’s goal is to improve the lives of the people of Louisiana by adopting and promoting the use of the patient-centered medical home model. The adoption of the NCQA standards and Joint Principles of the Medical Home, developed by the major medical societies representing primary care physician, are the bases of benchmarking our success.

The Quality Forum’s Medical Home Committee has convened the state’s major health care stakeholders for the purpose of developing and accelerating the adoption of standard components and criteria for the delivery of health care services via the patient-centered medical home system of care. This tool kit was produced as part of an effort to promote the delivery of superior care using standards based in medical evidence.

The Implementation Resource Tool Kit provides the following:

- General information about the Patient-Centered Medical Home including the philosophy and values developed around this model
- Links to medical home implementation guides and resource documents intended to provide practical “how-to” information for use in practices
- Process guide for systems change work necessary to implement the Patient-Centered Medical Home model in a practice
- Selected references on the Patient-Centered Medical Home and special populations such as the pediatric medical home model

If you have any questions or comments about the Implementation Resource Tool Kit materials or the implementation process, please contact Nicole F. Davis, MBA; Project Manager at the Quality Forum at nicole@lhcqf.org. We look forward to supporting your efforts to improve services to the citizens of Louisiana through the implementation of the patient-centered medical home model. Please share your experience in using this Implementation Resource Tool Kit. Feedback from users will help refine and improve future versions. You will find the Feedback Form at the end of the Implementation Resource Tool Kit.
Background

What are Patient-Centered Medical Homes?

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

The ACP, the AAFP, the AAP and the AOA have jointly defined the medical home as a model of care wherein each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians. A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients and physicians.”

Medical Home Information for Providers

A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

In a medical home, a physician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the physician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the patient and family.

The Medical Home is not a destination but a journey one takes with a family. A physician who takes on this challenge will meet many barriers but also find allies who will help ease the burden. Many of the barriers can be surmounted by:

- Education about chronic health condition management, the role of community and state agencies, school-related issues, and
- Reimbursement and practice management strategies.

There are resources to help practices meet these goals. In this tool kit, we provide a list of web sites to help guide the implementation of a medical home and provide evidence-based resources for the management of the chronic illnesses that will be encountered as efforts are undertake to improve the quality of care delivered. The ultimate goal is that practices will become more efficient and effective in delivering care for families.
In March 2008, the Louisiana Health Care Quality Forum voted unanimously to adopt the Joint Principles of the Patient Centered Medical Home (PCMH) policy statement, as the overarching description of the medical home for Louisiana. The Quality Forum believes these principles reflect those outlined by the Louisiana Health Care Redesign Collaborative and are consistent with the existing chronic care model and philosophical approach of federally qualified health centers all of which have been endorsed by providers, consumer groups and policy-makers in Louisiana. While much language contained in the attached document focuses on the “physician”, the committee believes that any design of a patient-centered medical home must be responsive to the locale of the individuals accessing care and the available resources; therefore, it is not required that the patient-centered medical home be physician directed. The definition of the model does not require a particular degree or license; however, it does require that functions and outcomes are delivered in a measurable manner by licensed providers.

The Basic “Must Pass” Elements for PPC-Patient-Centered Medical Home (See Section IV)

According to the NCQA, “The patient-centered medical home is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. In the “Patient-Centered Medical Home in Louisiana,” the Quality Forum Medical Home Committee references the NCQA “Must Pass” Elements from the Physician Practice Connections Patient-Centered Medical Home tool which became available in January 2008 at www.ncqa.org. For more information, please see the Quality Forum white paper on the Patient Centered Medical Home in Louisiana, Spring 2008. Some of the key attributes of the “must pass” elements are:

- Has written standards for patient access and patient communication
- Uses data to show it meets its standards for patient access and communication
- Measures clinical and/or service performance by physician or across the practice
- Reports performance across the practice or by physician
- Tracks referrals using paper-based or electronic system
- Tracks tests and identifies abnormal results systematically
- Actively supports patient self-management
- Adopts and implements evidence-based guidelines for three conditions
What is in this Implementation Resource Tool Kit?

This Implementation Resource Tool Kit is designed to provide information and ready resources to providers, payers, patients and purchasers interested in either learning more about or implementing the Patient-Centered Medical Home. The Implementation Resource Tool Kit provides the following:

- General information about the Patient-Centered Medical Home including the philosophy and values developed around this model
- Links to medical home implementation guides and resource documents intended to provide practical “how-to” information for use in practices
- Process guide for systems change work necessary to implement the Patient-Centered Medical Home model in a practice
- Selected references on the Patient-Centered Medical Home and special populations such as the pediatric medical home model

The Quality Forum is made up of volunteer stakeholders representing providers, patients, purchasers, and insurers. With participation from these diverse groups, we hope to gain momentum in moving the concept and principles of the patient-centered medical home forward to implementation throughout our state. The collaboration of all participants on the committee, the advisors, and the stakeholder advisory workgroup has demonstrated the usefulness of the adoption of cohesive standards, such as the NCQA guideline and the Joint Principles of the Patient Centered Medical Home.
Implementation Resource Links

I. Patient Centered Medical Home Overview

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006). In the spring of 2007, the AAFP and ACP teamed with the AAP and the American Osteopathic Association (AOA) to craft the Joint Principles of the Patient-Centered Medical Home.

The Quality Forum and its Medical Home Committee in its Patient-Centered Medical Home in Louisiana: A Progress Report, states “Louisiana has embraced the definition of a medical home as an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family as endorsed by the major professional medical societies.” The links below provide various perspectives and opinions on Medical Homes and change processes to support their development.

1. Commonwealth Fund/Modern Healthcare
   Health Care Opinion Leaders Survey on Views on Health Care Delivery System Reform by Martin-J. Sepúlveda, vice president of Well-Being Services & Health Benefits, IBM Corporation.
   link: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=678201

2. Association of American Medical Colleges (AAMC)
   link: http://www.aamc.org/newsroom/pressrel/2008/medicalhome.pdf

3. American Academy of Family Physicians (AAFP)
   The Medical Home An Idea Whose Time Has Come ... Again, by Leigh Ann Backer
   link: http://www.aafp.org/fpm/20070900/38them.pdf

4. American Academy of Pediatrics (AAP)
   Policy Statement of an expanded and more comprehensive interpretation of the concept and an operational definition of the medical home.
   link: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/1/184

5. Health Disparities Collaborative, Health Resources and Services Administration
   Planned Care Model for Changing Practice concept paper
   link: http://www.healthdisparities.net/hdc/html/about.hdcModels.aspx
6. **Institute for Health Improvement (IHI)**  
“The Model for Improvement”, developed by Associates in Process Improvement  
link: [http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/](http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/)

7. **American College of Physicians (ACP)**  
link: [http://www.acponline.org/advocacy/where_we_stand/medical_home/overview.htm](http://www.acponline.org/advocacy/where_we_stand/medical_home/overview.htm)

There are a number of organizations whose websites take a comprehensive approach to delivery system reform and are aligned with the Medical Home movement. Their websites where provider tools can be located are listed below along with brief explanatory information:

1. **National Committee for Quality Assurance (NCQA)**  
link: [http://www.ncqa.org/](http://www.ncqa.org/)

**Description:**  
The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda (NCQA).

**Importance:**  
This website provides current information on programs, HEDIS and quality measures, report cards, public policy, publications and products, education and events, and current news regarding those subjects. The NCQA offers accreditation programs, certification programs, and physician recognition programs.

**Features:**  
In addition to their Quality Measurement and Resource Tools, the NCQA has featured information on the Patient Centered Medical Home, Special Needs Plans, Multicultural Healthcare Awards, and information on choosing healthcare wisely.

A. **NCQA 2008 PPC-PCMH Standards and Guidelines**  
link: [www.ncqa.org/LinkClick.aspx?fileticket=3vQKgtlkp7g%3D&tabid=631&mid=2435&force download=true](http://www.ncqa.org/LinkClick.aspx?fileticket=3vQKgtlkp7g%3D&tabid=631&mid=2435&force download=true)

**Description:**  
To achieve recognition as a Patient-Centered Medical Home by meeting the NCQA PPC-PCMH standards, practices will attest to the 2007 Joint Principles of the Patient-Centered Medical Home of the AAFP, the AAP, the ACP and the AOA. Practices apply for recognition with the understanding that the PPC-PCMH standards assess many of the ways in which the practice functions as a patient-centered medical home. This document provides an overview, description of the current environment, historical perspective, quality rules, consumer perspective, PPC-PCMH development, examples of scorecards, PPC-PCMH scoring structure, PPC-PCMH recognition evaluation process, and it also references other valuable work in the Medical Home arena.
B. **NCQA Essential Guide to Health Care Quality**

**Description:**
In addition to information on health care quality, this guide also includes a list of quality initiatives and resources, a glossary of terms, and a list of relevant government and non-profit agencies. Chapter seven of this guide deals with Chronic Care. NCQA defines health care quality, shows what affects health care quality, its measures, pay for performance, health information technology, and they explore the government’s role and ideal models.

2. **Acumentra Health**
   link:  [http://www.acumentra.org/](http://www.acumentra.org/)

**Description:**
Acumentra Health works with healthcare providers, stakeholders and the public on health care issues. They offer quality improvement services and can provide a background in the areas of Electronic Medical Records/DOQ-IT and managed care models.

**Importance:**
Acumentra’s mission is to improve the quality and effectiveness of healthcare. The organization is important to the medical home movement because it aligns with medical home initiatives in quality improvement, use of medical records, and coordination of care, including mental health, and looking at the uninsured populations. Acumentra supported Oregon providers in numerous Medicare-sponsored improvement projects, such as the Patient Safety Alliance, which contributed to the success of the Institute for Healthcare Improvement’s 100K Lives Campaign. The organization also took a leadership role in projects in the state government and private sectors, including the Oregon Rural Collaborative and the Children’s Health Improvement Collaborative. (Acumentra).

**Features:**
Acumentra helps Medicare beneficiaries with telephone numbers, resources for beneficiaries, and questions and complaints about the review process. They offer services and programs such as Medicaid external quality review, performance measures, and improvement, utilization management and quality review, and QualityNet Exchange for Medicare providers. They have Quality Improvement tools and resources for healthcare professionals by topic and setting. They provide quality measurement tools, compliance, coding, and documentation tools, and Electronic Medical Record/DOQ-IT tools.
3. American Academy of Family Physicians (AAFP)

A. AAFP Family Practice Management Toolbox

   Description:
The AAFP provides The FPM Toolbox, offering more than 150 practice management tools. Many of these tools can be downloaded at no charge.

   Importance:
This toolbox provides forms, flow sheets, and coding guides to better manage a physician practice. This is important because the root of the medical home concept is the primary care physician’s office. This site provides examples to download and use that fit into the processes for making a primary care office into a medical home.

   Features:
The topics that the AAFP include are Billing and Claims Processing, Care Management, Career Management, Coding: CPT, Coding: ICD-9, Coding and Documentation, Computerization, Disaster Preparedness, Disease Management: Asthma, Disease Management: Diabetes, Disease Management: Influenza Pandemic, Encounter Forms, Financial Management, Flow Sheets, Group Visits, HIPAA, Inpatient Care, Life Balance, Managed Care, Medicare, Office Policy Samples, Patient Handouts, Patient Surveys/Questionnaires, Practice Improvement, Productivity, Referral Management, Risk Calculators, and Staffing.

B. AAFP Resources for Redesigning Your Practice

   Description:
AAFP presents Resources for Redesigning Your Practice. These tools will assist primary care practices in redesigning into a medical home.

   Importance:
Due to the lack of resources currently facing physician practices, the AAFP provides quick and easy tools and guides to accomplishing aspects of the medical home.

   Features:
The aspects of the medical home highlighted are: access to care-implementing same day appointments in your practice, group visits (shared medical appointments), office automation/computerization, online videos that demonstrate the office experience, and new health partnerships with the Institute for Healthcare Improvement. Also included is self-management support, a system of care that promotes patient/provider partnerships.
4. **Health Disparities Collaborative, Health Resources and Services Administration**  

**Description:**  
The Health Disparities Collaborative Web site is home for a community of learners who are committed to improving systems of health care. Using the methodology of the Planned Care Model and the Model for Improvement in the context of Community Oriented Primary Care, health centers are making a positive difference in the lives of hundreds of thousands of Americans (Health Disparities).

**Importance:**  
This site provides the centralized portal for communication as well as a forum for sharing the challenges, successes, tools of the trade and lessons learned. With the support of the Health Resources and Services Administration (HRSA), which is part of the U.S. Department of Health and Human Services, along with our strategic state and national partnerships, we are transforming systems of care to improve patient health outcomes and organizational sustainability (Health Disparities). This vision of improvement within the community oriented primary care aligns with the patient-centered medical home concept. Many of the ideas around their collaborative efforts tie into aspects of the medical home model, such as Business Case/Redesign, chronic disease management, and mental health as part of patient care.

**Features:**  
Health Disparities is focused on the collaborative areas of Clinical, Financial, and Operational. Under those areas are: Asthma, Business Case/Redesign, Cancer Screening and Planned Care, Clinical Risk Management, Management and Treatment of Depression, Prevention, Prevention and Treatment of Diabetic and Cardiovascular Disease, and Transplant Growth and Management Collaborative (TGMC).

5. **TransforMed Medical Home Implementation Quotient (MHIQ)**  
   Link: [http://www.transformed.com/MHIQ/welcome.cfm](http://www.transformed.com/MHIQ/welcome.cfm)

**Description**  
The TransforMED MHIQ is designed to make it easy to benchmark your practice's current performance. Answer a dozen or so short questions and get your current score in each of the eight areas, along with recommendations based on that score.

**Importance**  
Developed by TransforMed, an affiliate of the AAFP, this program allows providers to walk through a self-assessment of their practices medical home properties at their own pace. The MHIQ tool is cross linked with the NCQA PCC-PCMH tool.

**Features**  
Allows the provider to create an account and complete the assessment at their own pace including allowing the provider to log out of the system, but save the entered information.
II. Financing the Medical Home

With current payment models, most agree that physician practices will not be able to develop and sustain the Patient Centered Medical Home model. They will not be able to provide the amount of non-face-to-face work required, much less the technical infrastructure expected. In the Joint Principles, the professional societies make recommendations for payment reforms necessary to support the development and sustainability, as well as appropriately recognize the added value provided to patients who have a patient-centered medical home.

The links below are meant to be a resource of information on financing the Medical Home model as well as provide information on practice redesign and resource utilization.

1. Health Disparities Collaboratives

*Why Redesign and Finance?*

Description:
In Health Disparities website article, *Why Redesign and Finance?*, financing planned care is explored. According to Health Disparities, “Throughout the history of the Health Disparities Collaboratives, the major barrier reported by health center leaders has been the lack of a business case to support the work of Planned Care. The reality is that a front-end investment of time, staff and fiscal resources is required to implement the Planned Care Model. Unfortunately, the colloquial experience of most health centers is that this investment of resources is not offset by new revenues or cost reductions. Although there is a compelling case for the impact of the planned care model on decreasing health care utilization and costs, those savings generally accrue to the payers and hospitals rather than to the primary care providers. As a result, the senior leaders have kept repeating the mantra of *how do we pay for this work in order to sustain it*?” (Health Disparities). This article features an analytical look at redesign and finance. It also looks at measures. It provides additional resource links for independent research.

2. American Academy of Pediatrics (AAP)

*Coding and Reimbursement for CSHCN: KEY TO SOLVING REIMBURSEMENT PROBLEMS*

Description:
The purpose of this website is to give information on Coding. The AAP states that practices should “Improve coding skills to increase the financial health of your practice” (AAP).
“The Index of CPT Codes for Medical Home for The Pennsylvania Chapter of the American Academy of Family Physicians (AAFP) recently modified the “Crosswalk to Reimbursement” which identifies the range of relevant codes that could be used to finance components of a medical home. To view the modified document “Index of CPT Codes for Medical Home,” [click here](http://www.pafp.com/MMS/coding/medical-home-code-index.doc) (AAP).
The link for the CPT codes can be found above. [http://www.pafp.com/MMS/coding/medical-home-code-index.doc](http://www.pafp.com/MMS/coding/medical-home-code-index.doc)
3. American College of Physicians
Link:  http://www.acponline.org/advocacy/where_we_stand/medical_home/business_model.htm

Description:
Provides an overview of payment reform needed to support the medical home as well as links to more detailed policy statements and descriptions.

4. Patient Centered Primary Care Collaborative
Link:  http://www.pcpcc.net/

Description:
The Patient-Centered Primary Care Collaborative is a coalition of major employers, consumer groups, and other stakeholders who have joined with organizations representing primary care physicians to develop and advance the patient centered medical home. The site provides a detailed draft paper with recommendations to private payers about mechanisms to advance the Patient Centered Medical Home.

5. Deloitte and Touche Center for Health Solutions
Link:  http://www.deloitte.com/dtt/article/0%2C1002%2Ccid%25253D186574%2C00.html

Description:
The Medical Home: Disruptive Innovation for a New Primary Care Model examines medical home models, their savings potential, and the implications for policymakers and key industry stakeholders. The paper also offers compelling arguments in favor of medical home adoption. A detailed PDF is available from the website.
III. Pediatric Medical Home

The American Academy of Pediatrics is the forerunner in the Medical Home movement. The AAP has stated specific guidelines for a Medical Home, and although population specific, the underlying principles can be applied to any Medical Home model. The AAP came to consensus on the following principles of Medical Home:

1. Family- centered partnership: A medical home provides family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity and recognizing that they are the constant in a child’s life.

2. Community-based system: The medical home is an integral part of the community-based system, i.e., a family-centered coordinated network of community-based services designed to promote the healthy development and well being of children and their families. As such, the medical home works with a coordinated team to provide ongoing primary care and facilitate access to and coordinate with a broad range of community services.

3. Transitions: The goal of transitions is to optimize life-long health and well-being and potential through the provision of high-quality, developmentally appropriate, health care services which continue uninterrupted as the individual moves along and within systems of services from adolescence to adulthood.

4. Value: Appropriate payment for medical home activities is imperative. A high-performance healthcare system requires appropriate financing to support and sustain system-wide quality care with optimal health outcomes, family satisfaction, and cost efficiency (AAP).

The links below provide information on background, components of care, standards, and guidelines for the medical home. These sites are a select grouping out of the vast repository of knowledge on the Pediatric Medical Home initiatives. There is a myriad of research available on the Pediatric Medical Home.

1. American Academy of Pediatrics (AAP)

AAP Medical Home
link:  http://www.medicalhomeinfo.org/

Description:
This website is the AAP’s National Center for Medical Home Initiatives for Children with Special needs. “The National Center of Medical Home Initiatives for Children with Special Needs provides support to physicians, families, and other medical and non-medical providers who care for children with special needs so that they have access to a medical home” (AAP). This website covers a broad range in topics faced by the pediatric physician practice and is similar to those that surround the primary care patient-centered medical homes.
This website includes state pages, tools and resources, training programs and materials, screening initiatives, grant and funding opportunities, model programs, health topics, and medical home publications, as partially indicated by the following links:

1. **Training Programs and Materials**  
   link: [http://www.medicalhomeinfo.org/training/materials.html](http://www.medicalhomeinfo.org/training/materials.html)

   This category contains information on training and materials, including case studies, participant materials, appendices, and complete manual information on the following topics: Common Elements, Family-Professional Partnerships, Practices, Policies and Procedures, Comprehensive, Coordinated, Collaborative Care, Transitions, State and Local Advocacy, and Surveillance and Screening.

2. **Health Topics**  
   link: [http://www.aap.org/healthtopics](http://www.aap.org/healthtopics)

   The Health topics category covers a variety of topics related to the medical home. Some featured items are immunizations, mental health, ADHD, autism, car seats, obesity, and disaster preparedness.

3. **General Pediatrics**  
   link: [http://www.brightfutures.aap.org/](http://www.brightfutures.aap.org/)

   Bright Futures is a national health promotion and disease prevention initiative that addresses children’s health needs in the context of family and community. In addition to use in pediatric practice, many states implement Bright Futures principles, guidelines and tools to strengthen the connections between state and local programs, pediatric primary care, families, and local communities.

2. **National Network for Immunization Information (NNII Immunizations)**  
   link: [http://www.nnii.org](http://www.nnii.org)

   **Description:**  
   The National Network for Immunization Information (NNii) provides current, science-based information and is affiliated with the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, the American Academy of Pediatrics, the American Nurses Association, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, the American College of Obstetricians and Gynecologists, the University of Texas Medical Branch, the Society for Adolescent Medicine and the American Medical Association (NNii). This website features searchable links on vaccines and the diseases they prevent.
3. **Center for Medical Home Improvement**
   link: [http://www.medicalhomeimprovement.org/outcomes.htm](http://www.medicalhomeimprovement.org/outcomes.htm)

**Description:**
"The mission of the Center for Medical Home Improvement is to establish and support networks of parent/professional teams to improve the quality of primary care medical homes for children and youth with special health care needs and their families” (CMHI). The CMHI provides numerous links and resources to help those who serve children and youth with special needs, but the comprehensive nature of their endeavor could be translated into working with other populations. The medical home improvement kit they feature is very informative and could be used to model other medical home movements.

The CMHI website features links to the following: Medical Home Improvement Kit, Parent Partner Guide Medical Home Measurements, Medical Home Practice-Based Care Coordination, CMHI PowerPoint Presentation, Explaining the Medical Home - Talking Points, and CMHI Consultation Services. The website also features Medical Home Practice-Based Care Coordination, CHMI Medical Home Index with transition to Adulthood indicator #2.5.1 revised, and the CHMI Medical Home Index-Short Version-2006.

4. **Coordination of Care - Med Home Portal**
   link: [http://www.medhomeportal.org/about/care-coordination](http://www.medhomeportal.org/about/care-coordination)

**Description:**
This is the Utah Med Home Portal. It is a robust, searchable website on the medical home movement in the state of Utah. Its target population is children and youth with special needs. The Utah Med Home Portal features information about medical home, care coordination, optimal coding, about MedHome Portal, portal orientation, medical home training and resources, newsletters and conference calls, and conferences and community events that are searchable topics.
IV  Key “Must Pass” Elements

The NCQA, in concert with major professional medical societies, has developed a structural definition of the PCMH designed to help define the entity for patients, providers and payers. The product is the culmination of a 6 to 7 year effort to create reliable and valid measures of the chronic care model. The existing Physician Practice Connections (PPC) 2006 tool was modified with input from ACP, AAFP, AAP and AOA; it incorporates critical attributes of the PCMH. The existing “tool” (available 1/3/08 NCQA) is recognized for “qualification” of PCMH by ACP, AAFP, AAP and AOA. Practicing physicians, health plans, employers and consumers have been exposed to this “tool” at numerous presentations via Web-ex’s and at regional and national meetings.

The PPC-PCMH Content and Scoring document consists of 9 standards with elements to each standard; and with points associated with each standard. Totaling the points for all the standards results in a PPC-PCMH score; a practice can score up to 100 total points. There are also “must pass” elements included in the scoring process and practices are required to pass a certain percent of these elements. Presently NCQA recognizes 3 levels qualifying as PCMH:

- Level 1 requires 25-49 points and 5 of 10 must pass elements
- Level 2 requires 50-74 points and 10 of 10 must pass elements
- Level 3 requires 75 -100 points and 10 of 10 must pass elements

Reference links for the “must pass” elements are listed below according to the element.

Element 1: Has written standards for patient access and patient communication (Uses data to show it meets its standards for patient access and communication)

1. **Institute for Health Improvement (IHI)**
   

   **Description:**
   Discussion group postings regarding improving access to practices, how to get started, reducing the backlog of appointments.

2. **AAFP**
   
   The AAFP covers a variety of topics on access to care related to the medical home. Some feature items are open access scheduling, no shows, phone systems, panel size, and group visits. These are featured in resource links below.

   **A. Open-Access Scheduling:**

   **B. No-shows**

   **C. Phone Systems:**
D. Panel Size:

E. Group Visits:

Element 2: Measures clinical and/or service performance by physician or across the practice

1. TransforMED
link: www.transformed.com

Description:
TransforMED is focused on practice redesign and affiliated with the American Academy of Family Physicians (AAFP). According to Dr. Terry McGeeney, “The Practice Enhancement Forum program info is soon to be available through TransforMED. It is a 120-130 question Medical Home Self-Assessment tool .... Practice Support Division staff is also developing a resources manual to help practices achieve various levels of NCQA PCMH designation though not yet available” (TransforMED).

2. AHRQ
link: http://www.ahrq.gov/qual/aqastart.htm

Description:
This AHRQ website is a link for Recommended Starter Set on The Ambulatory Care Quality Alliance for Clinical Performance Measures for Ambulatory Care.

3. AAFP

Description:
This website is about the METRIC: Measuring, Evaluating and Translating Research Into Care. It is an innovative online practice improvement program which allows one to earn CME credit in one’s office while improving patient care. The program is designed to assist family physicians in fulfilling the requirement for Part IV of Maintenance of Certification” (AAFP).

4. NCQA

Description:
NCQA has developed a series of training programs for each of the Physician Recognition Programs to help with the application and submission process. This program features an introductory workshop on standards, how to use survey tools, how to use data collection tools, and suggestions for future training.
Element 3:  Reports performance across the practice or by physician

1.  Institute for Health Improvement (IHI)
   link:  http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.htm

   Description:
   This website is a “fee for service” offer of web-based training courses. These courses rely on an online system which utilizes drill and practice, simulations, questioning, answering, and reading to give the user a robust learning opportunity.

2.  AAFP

   Description:
   The AAFP has numerous links to Quality Improvement (QI) Tools & Resources. A few of them are “Project”, Implement a QI Project in Your Practice”, “ Research Clinical Information Systems & Decision Support”, “ Performance Measurement & Pay-for-Performance”, “ Patient Safety in the Primary Care”, “ Office Resources for Redesigning Your Practice” , and “Medicare Quality Improvement Community” (MedQIC).

Element 4:  Tracks referrals using paper-based or electronic system

AAFP
link:  http://www.aafp.org/fpm/20020300/39redu.html

Description:
A sample referral agreement and an article with assistance for practices in developing referral guidelines.

Element 5:  Tracks tests and identifies abnormal results systematically

AAFP
link:  http://www.aafp.org/fpm/20070600/37meas.pdf

Description:
This article on PQRI – CPT II measures for reporting outcomes laying out the process of reporting date using this system, choosing measures, collection, reporting and analyzing data. Includes easy to understand examples of reporting and analysis tools.
Element 6: Actively supports patient self-management

IHI
link: http://www.ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/EmergingContent/EmergingContentIndex.htm

Description:
Website contains learnings from the “Pilot Collaborative on Self-Management Support” which implemented models of self-management in six pilot site practices as well as the "New Health Partnerships: Improving Care by Engaging Patients" initiative (formerly known as Quality Allies) supported by RWJF and the California HealthCare Foundation. The initiatives are working to involve patients and families in the design of care, leverage IT to enhance self-management, and improve the business model for ambulatory care practices to implement self-management programs.

Element 7: Adopts and implements evidence-based guidelines for three conditions

1. Institute for Healthcare Improvement

A. White paper “describing principles and strategies used successfully in other industries to help evaluate, calculate, and improve the overall reliability of complex systems, and explains the application of reliability principles to health care” (IHI).
link: http://www.ihi.org/IHI/Topics/Reliability/ReliabilityGeneral/

B. Website features an article on the Chronic Care Model and has a link to “Chronic Care Model Audio Presentation-A 50-minute presentation that gives a step-by-step narration of the Chronic Care Model” (IHI).
link: http://www.ihi.org/IHI/Topics/ChronicConditions/

2. Improving Chronic Illness Care, Robert Wood Johnson Foundation

link: http://www.improvingchroniccare.org/
link: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Description:
Websites cover a variety of topic on improving chronic illness related to the medical home and features links to model elements of chronic care, model talk, models in action, RAND evaluation, CCM Gallery, how to cite the CCM, and tackling the chronic care crisis.
3. National Heart, Lung, Blood Institute

Reports and guidelines for the chronic illnesses listed below.

A. Cholesterol [ATP III]:

B. Hypertension [JNC VII]:

C. Asthma [NAEP]:
   Link: http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf

4. United States Preventive Service Task Force-AHRQ

AHRQ provides a summary of recommendations and supporting documents for a variety of illnesses as listed below. Screening for breast cancer, cervical cancer, and colorectal cancer, then provides:

A. Cancer Screening:
   1. Link: http://www.ahrq.gov/clinic/uspsf/uspsbrca.htm
   2. Link: http://www.ahrq.gov/clinic/uspsf/uspscerv.htm

B. Mental Health and Substance Abuse:
   1. Link: http://www.ahrq.gov/clinic/uspsf/uspstbac.htm
   2. Link: http://www.ahrq.gov/clinic/uspsf/uspsdrin.htm

5. Centers for Disease Control

These websites contain adolescent and adult immunization schedules.

1. Link: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5540-Immunizationa1.htm
2. Link: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5701a8.htm?s_cid=mm5701a8_e

6. American Diabetes Association

Link: http://professional.diabetes.org/

Description: This website features a search called Diabetes Pro, a professional resource online.
7. **Health Disparities**
Website covers a variety of topics on chronic illness related to the medical home listed below, including an overview of the topic, then topical content related to the chronic illness, then required measures. Specific tools, measures and team experiences can be found on these sites.

1. **Asthma**
   link: [http://www.healthdisparities.net/hdc/html/collaboratives.topics.asthma.aspx](http://www.healthdisparities.net/hdc/html/collaboratives.topics.asthma.aspx)

2. **Cancer**

3. **Cardiovascular Disease**
   link: [http://www.healthdisparities.net/hdc/html/collaboratives.topics.cvd.aspx](http://www.healthdisparities.net/hdc/html/collaboratives.topics.cvd.aspx)

4. **Depression**
   link: [http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx](http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx)

5. **Diabetes**
V. Health Information Technology Supporting the Medical Home

Health information technology (HIT) is widely believed to facilitate improved quality, safety, and efficiency of care. Much of the momentum surrounding the adoption of HIT comes from two landmark Institute of Medicine reports, To Err is Human: Building a Safer Health System, published in 1999, and Crossing the Quality Chasm: A New Health System for the 21st Century, published in 2001 [1, 2]. Research conducted since the mid-1990s has generally supported the ability of specific HIT applications to reduce medication errors, increase delivery of care based on guidelines, enhance monitoring and surveillance, and decrease utilization for redundant or inappropriate care. HIT tools such as electronic medical records and information exchange are an important supports for physician practices that can rapidly advancement the development of the patient-centered medical homes.

The links below provide information to support physician practice knowledge and use of various aspects of HIT.

1. AAFP’s Center for Health Information Technology
   link: http://www.centerforhit.org/

   Description:
   This website features information about preparation, selection, implementation, and maintenance associated with adoption of electronic health records. It provides an interactive, informational guide to assist physician offices that have not implemented EHR. The website contains tool kits and readiness assessments for members only.

2. The AHRQ National Resource Center
   link: http://healthit.ahrq.gov

   Description
   Part of its health IT initiative, AHRQ’s National Resource Center is designed “to help the health care community make the leap into the Information Age. In addition to providing technical assistance, the National Resource Center shares new knowledge and findings that have the potential to transform everyday clinical practice. AHRQ’s National Resource Center is committed to advancing our national goal of modernizing health care through the best and most effective use of IT. As new findings and data become available to the health IT community from both the AHRQ portfolio of projects and other sources, they will be shared on this site.”

   A. White paper on AHRQ on the relationship of Health Information Technology and Primary Care. The paper explores the relationship of HIT and improvement HIT functionality for improving quality of patient care, change concepts, implications, and opportunity for HIT in primary care.

   link: http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_661809_0_0_18/AHRQ_HIT_Primary_Care_July07.pdf
B. Health IT Bibliography, “a collection of carefully selected, high quality resources for health care and information technology (IT) stakeholders searching for information on how health IT can transform care delivery processes and improve quality, safety, and efficiency”


3. California Primary Care Association (CPCA) Free Registry
link: http://www.c pca.org/healthcollabs/issupport/bphcis.cfm#cvdens

Description:
Free download of Bureau of Primary Health Care Patient Registry Software: Cardiovascular/Diabetes Electronic Management System (CVDEMS) & Patient Electronic Care System (PECS) as well as information about the registry programs developed by the Bureau of Primary Health Care for the use in the Collaborative. The website features links to the clinical information systems, cardio/diabetes electronic medical systems, patient electronic care systems, reporting in the collaborative, and FAQ on the systems.
VI. Guiding the Change Process for Implementation of the Medical Home

There is significant research around effective methodology for strategies to build consensus and implement change in systems. The proposed community model below is an adaptation of current thinking on consensus building to help prepare the primary care practices for change and implementation of the medical home model of care.

This model is derived from the experts at the Center for Mental Health Services’ (CMHS) recommendations around community models of consensus and change, and then applied to the medical home movement. It represents a single approach, and links to other models of change management are provided under the Resource Links section.

There are four key steps to effect systems changes: Prepare, Plan, Implement, Evaluate and Improve.

1) Prepare: Identify key leaders to develop a vision for the medical home and convey that vision to all stakeholders. Support for the implementation of the medical home can be generated by communicating how the medical home model benefits all stakeholder groups. Articulate how the change will assist one’s practice in fulfilling its mission, that is, providing quality healthcare.

2) Plan: Establish a medical home implementation leader and team which include representatives from all stakeholder groups. Provide the team with information which will help to identify and overcome obstacles to successful implementation. This team is charged to develop an implementation plan. The responsibilities of the medical home implementation leader and team include:

   o Identify administrative support and system changes needed to support the medical home model within your personnel and your business processes.

   o Develop an assessment of training needs for the medical home model.

   o Connect practitioners with others in similar roles, i.e., physician to physician, case manager to case manager.

   o Educate practitioners about studies that demonstrated the effectiveness of the program.

   o Establish a medical home implementation timeline.

   o Anticipate the change’s impact on operations.
3.) **Implement**: Involve staff at all levels to support the medical home implementation. From the beginning, implementation should include sustainability planning. The implementation leader should design the process with the goal of the incorporation of new processes and procedures being natural and easy for the practitioners to conduct. Generally, it takes a year for a comfortable and confident level to be achieved.

Strategies for motivating staff to implement the new model include:

- Holding a “kick-off” meeting where all stakeholders receive information about the medical home to give those involved an opportunity to learn and voice their opinions.
- Provide comprehensive skills training session for staff who will provide the medical home services.
- Visit programs that have successfully implemented the medical home model.

4.) **Evaluate Outcomes and Improve**: Establish a method for continuous feedback and improvement regarding how the medical home model is affecting the quality of care, the consumer perception of the practice, and the cost to administer care using the medical home model.

Components of effective process improvement include:

- Address the critical issue of ongoing project maintenance.
- Review outcome measures and learn how to use them to make adjustments in the practice procedures and processes.
- Make known the quality improvement outcomes achieved from utilization of the medical home processes.
- Utilize evaluation results to establish benchmarking for future goal setting, budgeting, and staffing.
VII. References


http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf.


LHCQF. Medical Home Committee. Louisiana Health Care Quality Forum. Website: Last update April, 2008.

Accessed April 21, 2008.


VIII. Feedback

In an effort to improve our tool kit we ask that you respond to the following questions:

- What do you find most useful about the Implementation Resource Tool Kit?

- What do you find least useful about the Implementation Resource Tool Kit?

- What are your suggestions for improving the Implementation Resource Tool Kit?

Please send comments and suggestions to the Louisiana Health Care Quality Forum:

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