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Medical Home NEWS

The Unsung Component of the Patient-Centered Medical Home: Clerks

By Ron Shinkman

In "Clerks," the 1993 comedy that put director Kevin Smith on the map, the eponymous characters are foul-mouthed, rude to customers and far more devoted to playing hockey on the rooftop of the video store where they work than actually working. That virtually all movie rentals are now transacted via kiosk or mail suggests the logical endpoint of that film.

Such clerks with such a work ethic in a healthcare setting would be an unmitigated – and unfunny – disaster. But highly competent clerks in healthcare settings such as patient-centered medical homes, can play a vital role in ensuring the continuity of care for patients and solidifying their overall satisfaction with their medical practice.

That's the experience of Samantha Solimeo. She's a medical anthropologist by training who is both a researcher with the Veterans Affairs Administration and an assistant professor of internal medical with the University of Iowa's Carver College of Medicine.

"Clerks can deliver quite valuable services, particularly in an integrated care setting," Solimeo said.

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How Medical Homes Can Take Pressure Off of Safety Net Clinics

By Li-Hao Chu, Michael Tu, Yuan-Chi Lee, Jennifer N. Sayles, M.D., and Neeraj Sood

Safety net clinics play a pivotal role in delivering both primary and specialty care to millions of low-income Californians. These clinics are comprised of licensed primary care clinics, clinics operated by government entities (counties and cities), and clinics operated by federally recognized Indian tribes or tribal organizations. Safety net clinics provide care to medically underserved populations, regardless of their ability to pay.

In 2011, the State of California authorized a section 1115 Medicaid waiver that mandated enrollment of seniors and people with disabilities (SPD) in managed Medicaid plans. This in turn led to an influx of patients with chronic conditions into safety net clinics.

According to data from the California Public Policy Institute, the state's Medicaid population is associated with frequent hospital admissions and heavy reliance on hospital emergency departments (EDs). Medicaid provides insurance to underserved, minority, and low-income patients—the populations most susceptible to fragmented and uncoordinated care. This is not a surprise; Medicaid beneficiaries use the ED at an almost two-fold higher rate than the privately insured, although research has suggested that many utilizers of the ED have fairly serious health issues.

If Medicaid and uninsured patients are not going to hospital EDs, they will turn to safety net clinics. Such clinics can play an important role in reducing the use of care at hospital emergency rooms, which is usually the most expensive setting to receive services, particularly for non-acute issues.

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Editor's Corner

We continue our op-eds with the first of three articles from Kip Sullivan discussing the financial viability of patient-centered medical homes. A version of this article originally appeared at The Health Care Blog.

Kip Sullivan, J.D., is a Minnesota-based expert on healthcare policy. He was a consumer representative for the Minnesota Governor's Health Plan Regulatory Reform Commission in the 1980s, and advocated for universal health coverage as a health systems analyst for the Minnesota Universal Health Care Coalition. He is a member of Physicians for a National Health Program.

Medical Homes Aren't Cutting Costs

The Medicare Payment Advisory Commission (MedPAC) believes Medicare ACOs and "medical homes" are unlikely to qualify as "alternative payment models" under MACRA (the Medicare Access and CHIP Reauthorization Act).

In this article I will review the evidence supporting MedPAC's pessimistic assessment of "patient-centered medical homes" (PCMHs). I will review evidence that PCMHs are not cutting Medicare costs but are probably inflicting financial and emotional stress on many PCMH clinics. In a future post I will review the evidence on Medicare ACOs. Down the road I hope to comment on bundled payments. PCMHs, ACOs, and bundled payments are the three templates available to CMS to fashion APMs.

Within five years after the PCMH fad appeared, CMS had begun three demonstrations to test the ability of PCMHs to lower Medicare costs while simultaneously improving quality. The first of these demos, the FQHC Advanced Primary Care Practice Demonstration, ended in October 2014. The other two, the Comprehensive Primary Care (CPC) Initiative and the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, will end this year.

CMS has released evaluations of the first two years of the FQHC and CPC demos, and an evaluation of the first year of the MAPCP demo. CMS has delayed the second-year evaluation of the MAPCP demo.

The findings presented in these evaluations are not good news for PCMH supporters. In a recent report, the Kaiser Family Foundation (KFF) offered this summary of the results of the three PCMH demos: "Among the office-based multi-payer models (MAPCP and CPC) and the FQHC/APCP model, little to no savings have been generated after accounting for the outgoing Medicare expenditures in care management fees."

KFF could have been a tad harsher in their judgment: The evaluations suggest the three demos together are raising Medicare's costs when Medicare's payments to PCMHs are taken into account. The evaluations of the CPC and MAPCP demos have reported no statistically significant change in Medicare spending, while the evaluation of the FQHC demo reports that FQHC "homes" are raising Medicare costs by a statistically significant amount.

Here is what the RAND Corporation said in its evaluation of the FQHC demo in its July 2015 second-year evaluation: "As of the end of the demonstration's ninth quarter, we know that costs for demonstration sites are higher than for comparison sites…. These cost findings … suggest that it is unlikely that overall costs associated with the demonstration at its completion will be lower for demonstration FQHCs than for comparison FQHCs."

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The Unsung Component Of The PCMH…*continued from page 1*

Where Medical Clerks Make A Difference In Healthcare Delivery

The U.S. Military

From the U.S. Army's Tripler Medical Center website: "A patient's PCMH consists of a physician, physician assistant or nurse practitioner civilian, military and contract case managers, registered and licensed nurses, 68 Ws (a military designation for healthcare specialist), medical technicians, medical assistants and medical clerks." The military's Beneficiary Instant Physician Appointment Scheduling System (BIPASS) is also regularly monitored by clerks, potentially speeding up care delivery to patients as they appear for their appointments.

School-Located Influenza Vaccination Program, Alachua County, Florida

Nearly 13,000 students in Alachua County received influenza vaccinations at their schools during the 2013-14 school year. Clerks paid $15.60 an hour played a valuable role in checking the accuracy of patient information and entering data into Florida's vaccine registry. A study published earlier in the journal *Vaccine* concluded such in-school programs are financially viable when enough privately-insured students are vaccinated.

VA Healthcare System

A 2015 study in the International Journal of Operations & Production Management concluded that the Department of Veterans Affairs could significantly reduce call waiting times by a minor redeployment of clerks. Some clerks were assigned to answering phones, while others were assigned to checking in patients. When the latter were assigned to answering phones during their "down time" (roughly 50 percent of their workday), waiting times on the phone plummeted, while fewer patients hung up while being placed on hold.

Hospital Emergency Departments

Clerks can play a vital role in obtaining and relaying information to clinicians regarding a patient's medical complaint and help them make a rapid determination as to whether the patient should be treated in an ED or a less-intensive primary care setting. A 2013 study published in the *Journal of Healthcare Management* concluded that hospital costs were significantly reduced in a model where clerks quickly transmitted intake information to caregivers.

In popular culture, clerks have often been portrayed as feckless (as in Smith's movie), timid (think Bob Cratchit of "A Christmas Carol"), or more recently, even condescending or rude (many, many films and television shows).

That may be because clerks often also act as receptionists. Both their demeanor and their surroundings set a tone, whether it is a government office or a medical practice. "You know the difference – you walk in, you see a reception area that is behind frosted glass window that is closed. That is not a patient-centered medical home," said David N. Gans, a senior fellow of industry affairs with the Medical Group Management Association.

Moreover, in a medical practice where the caregivers often have a decade or more of post-secondary education, clerks are on the lower end of the pecking order. Most are paid less than $35,000 a year; few have education beyond a two-year degree from a community college.

But clerks, although they do not make what Solimeo observed is a "biomedical" contribution to the care of patients, still play an important role in the delivery of care in medical home settings. Many studies on the topic will mention a clerk as being part of the care team.

And while healthcare academics study care delivery from the perspective of a particular change in clinical practice -- such as using a generic form of medication or the use of a therapy over a surgical intervention – an anthropologist such as Solimeo scrutinizes how the system works holistically, focusing on interactions among the various participants.

According to Solimeo and her research team at the Iowa City VA Health Care System, making a clerk part of the care team is an important distinction. It is particularly critical given the need for medical homes to provide flexibility in ensuring the patient can get in and see a caregiver nearly on demand.

"The physicians, nurse practitioners and physician assistants are obviously delivering the care. But the clerks can really make a difference as to how quickly a patient can get that care," she said. "And they can help ensure that each clinician is practicing at the very top of their license."

In an organization such as the VA, flexibility is paramount. The VA system has received an inordinate amount of bad publicity in recent years due to backlogs of patients unable to see a doctor, with some contentions that patients were dying due to lack of accessibility. Its own medical home model, known as the Patient-Aligned Care Team (PACT) and begun in 2010, is partly intended to make the continuity of care more smooth and improve outcomes. The PACT care team is comprised of a physician, a nurse practitioner or physician assistant, a registered nurse, a licensed practical nurse and a clerk.

Clerks can make a difference in addressing patient backlogs, particularly if they are deployed carefully, according to Solimeo.

One striking example of this surfaced last year in a study published in *the International Journal of Operations & Production Management*. It examined the VA's Telephone Advice System line, where patients can call in regarding the renewal of medications. Only 15 percent of calls were answered within the optimal time of 20 seconds.

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The Unsung Component Of The PCMH...*continued from page 1*

Medical Clerks: A Professional Breakdown

Educational Requirements: High School diploma or associate's degree

Pay: $9 to $17 an hour

Responsibilities: Receiving and logging in patients, managing appointments, taking basic medical histories, answering phones, relaying information to other members of the patient-centered medical home.

Projected job growth: 22 percent between 2012 and 2022 (U.S. Bureau of Labor Statistics)

Critical Responsibilities: Clerks often serve as the first interaction a patient will have when they contact their provider or arrive in person. Their comportment and attitude often influence how a patient perceived their medical practice.

Potential Drawbacks: Although studies have suggested clerks are less susceptible to work "burnout" than other members of medical homes, those with too much of a specific responsibility (e.g., answering phones without other duties), can become dissatisfied with their work much more quickly.

Some call answered were delayed 25 minutes or more, with a handful waiting on hold more than 45 minutes before being picked up by a clerk. Many patients were simply hanging up and getting on with their day, but without their prescriptions being filled or other potentially significant healthcare issues being addressed.

The study determined that the VA was dividing clerks into two specific job duties: Either answering the phones, or checking patients in and out. The former were occupied 90 percent of the time with that particular job task, while the latter was occupied only about half of the time. The group only answering phones tended to be at higher risk of burning out and leaving the job.

The researchers, with the VA and North Dakota State University, concluded that pooling the phone duties among PACT clerks would reduce call waiting times from an average of nearly three minutes to less than 30 seconds, with more than 80 percent of calls answered within 20 seconds and more than 96 percent of all calls answered. In such an environment, patient satisfaction would no doubt increase.

"Emotional Labor"

In addition to being deployed in a way to improve access to care, clerks usually are charged with the task of updating patient information such as addresses and telephone numbers. That means they often interact with patients on a non-clinical level. In such a situation, patients are more likely to be forthcoming with personal details about their lives with the clerks than with the doctors or nurses. Solimeo refers to this as "emotional labor." This kind of labor can prompt the clerk to personally vest with the patient. Conversely, since the patient usually makes the appointment through the clerk, they are also more likely to hold them accountable for situations they cannot always control.

Although this sounds harrowing on its face, this kind of relationship can prove extremely useful in terms of ensuring the continuity of care. One example from a 2016 study undertaken by Solimeo: An elderly patient who had gotten lost on the way to their appointment and appeared 15 minutes late.

The clinician wanted to reschedule; the clerk intervened and the patient was seen. This kind of dynamic can be reinforced even further within an organization such as the VA, where clerical staff are more likely to be military veterans than in other healthcare institutions. The desire for one veteran to help another can be especially powerful, according to Solimeo.

And since the labor tasks of clerks are more straightforward than clinicians, they are more likely to suggest ways patients can string appointments together, ensuring they undergo lab tests and other encounters during a single visit. This kind of interaction can be used to significantly reduce patient no-shows for appointments, Solimeo observed.

Nevertheless, while clerks may be considered part of the medical home model, in a system such as the VA's PACT, they are often relegated numerous responsibilities in order to ensure the clinicians can provide care optimally. For instance, clerks are may be included in a team's quality improvement projects, but when conferences are scheduled to discuss such initiatives, the clerks are often left in the front area, staffing the phones and unable to collaborate with their team.

That can create a conundrum of its own.

Samantha L. Solimeo, PhD., MPH

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The Unsung Component Of The PCMH…*continued from page 4*

As Solimeo remarked in her 2016 study: “Clerks work in the clinic’s most public space where they become the visible representation of the team, yet within the larger organization, much of clerks’ care work remains invisible as care. Clerks’ care work is further devalued through organizational practices resulting in clerical staffing shortages and an accompanying organizational practice of viewing clerks as interchangeable workers, thereby inhibiting their full integration into PACTs.”

As a result, in 2013 up to 10 percent of PACTs lacked an assigned clerk, and more than a third were sharing them among one another. And the role of clerks is rarely mentioned in PACT training presentations.

…in 2013 up to 10 percent of PACTs lacked an assigned clerk, and more than a third were sharing them among one another. And the role of clerks is rarely mentioned in PACT training presentations.

Moreover, clerks are more likely to be reassigned where needed, and call handling can be centralized as an efficiency measure. This can further disrupt the care being delivered inside a medical home setting.

Solimeo noted that this marginalization of clerks is the result of a variety of factors, including the fact that clerks are non-clinicians and at the bottom of the hierarchy of healthcare delivery. They are also often positioned in the nexus between the patient reception and clinical care areas, subjecting them to work interruptions by both medical staff and patients.

Nevertheless, the role of clerks in the medical home is continuing to draw more attention. Amaranth Banerjee, an assistant professor in the engineering department of Texas A&M University, is focused on research that would improve how patient appointments are processed and handled.

“The objective is to develop a balanced schedule that tends to minimize both the waiting time for patients as well as idle time for physicians,” Banerjee said. “The waiting time increases if there are too many patients that are scheduled while the idle time increases if there are not enough patients.”

No doubts clerks will play a role in how a perfectly balanced schedule for patient-centered medical homes works out.

“Clerks may not be the most important part of the medical home,” Solimeo observed. “But they are important, and they should be considered integral.”

How Medical Homes Can Take Pressure Off…*continued from page 1*

In light of this knowledge, L.A. Care Health Plan, the nation's largest public insurer, initiated a pilot program to transform selected safety net clinics into patient-centered medical homes (PCMHs) in the hopes of improving patient care and alleviating the impact of the SPD influx.

The intervention of this program focused on providing implementation of:

- On-site and virtual technical assistance on topics like optimizing team-based care, patient experience, population health management, care coordination, and patient access to care
- Workflow analysis and process improvement
- Access to subject matter experts on key topics like care coordination
- Provision of customized coaching training
- Administration of the PCMH assessment

A variety of studies have concluded PCMH pilot programs in integrated delivery systems and multipayer–sponsored initiatives have shown promise in improving the quality of patient care, reducing hospitalization and ED visits, and lowering Medicaid costs. More than half of the states have implemented payment policy changes and other reforms to Medicaid to help primary care providers’ function as PCMHs.

Our research focuses on the impact of PCMHs on a previously untested population: Safety net clinics serving the greater Los Angeles area, the nation's second most-populous city and seat of the nation's most populous county. The transition to the PCMH model coincided with the state-mandated switch of SPDs from fee-for-service to a managed Medicaid plan.

This switch created a potential complication: The new, high-use SPD members—with their demand on health services being much higher than regular Medicaid members—could potentially crowd out or delay routine medical services for all other Medicaid recipients at safety net clinics.

This study was based on L.A. Care's initiation of a PCMH-based pilot project.

Among 11 safety net clinics in the greater Los Angeles area in early 2012 that had been designated by the NCQA or other accrediting body as capable of serving as a PCMH, seven were included in the study because they contracted to provide care for at least 300 of L.A. Care's members.

We used administrative claims data from 2011 through 2013 in the analysis. The study timeframe spanned prior and post-PCMH transformation. Independent variables included indicators for years 2012 and 2013 (with 2011 serving as a reference), members’ demographics and co-morbidities, and interactions between time periods and PCMH/non-PCMH status.

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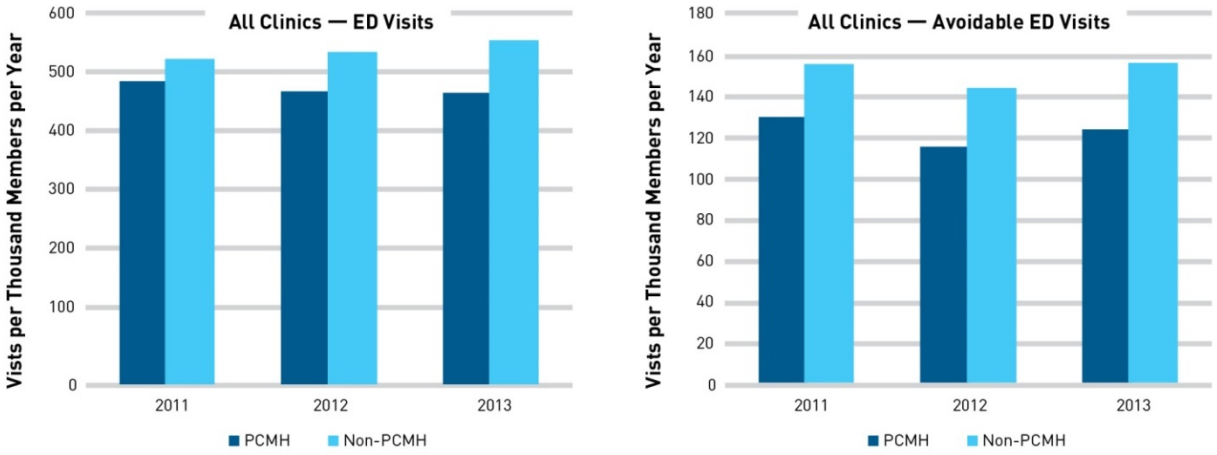
How Medical Homes Can Take Pressure Off *...continued from page 5*

Across the three years of the study, an average of 23,662 members were in the PCMH group and 138,152 were in the non-PCMH group. The distributions of age categories, gender, and co-morbidities in 2011 were similar between the two groups. Seventy percent of the study population was younger than 18 years old. However, the proportion of Hispanics was 6 percent to 7 percent higher in the non-PCMH group.

PCMH clinics in the study offered extended hours including weekends, and a helpline. Only one non-PCMH clinic had extended hours. PCMH clinics also tend to offer more disease management programs. One PCMH clinic stated that health IT was useful in informing and improving decisions. There were no conclusive findings on the attributes related to quality of care and patient engagement, however.

In the pre-PCMH period, the PCMH clinics had 32 fewer ED visits and 22 fewer avoidable ED visits. Following implementation of the PCMH model, the use of ED visits declined much faster in PCMH clinics than non-PCMH clinics.

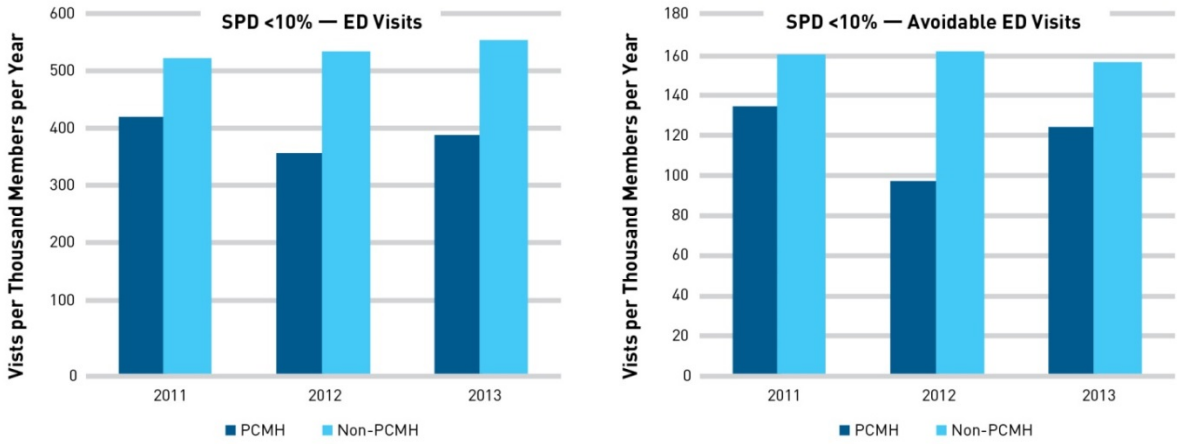
Unadjusted Comparison of ED Visits and Avoidable ED Visit Between PCMH and Non-PCMH Groups



As a result by 2013, PCMH clinics had 70 fewer ED visits and 24 fewer avoidable ED visits. We found no evidence of differing trends in inpatient hospital care by PCMH status. In contrast to trends in ED visits, PCMH clinics experienced a more rapid increase in office visits. In the pre-PCMH period, PCMH clinics had 77 fewer office visits. In 2013, however, this difference reversed, and PCMH clinics had 163 more office visits. Overall, the trends in use suggest that increased access to primary care in PCMH clinics might have resulted in less frequent use of hospital EDs.

Other studies have suggested widespread inappropriate use of the ED among Medicaid beneficiaries can be attributed, in part, to unmet health needs and lack of access to appropriate primary care. Similarly, our interview results show that when PCMH clinics had improved access to care, the ED use was reduced.

The PCMH clinics tended to begin with lower ED rates than the non-PCMH clinics in the pre-implementation period. One possible explanation is that the cutoff dates of the pre- and post- periods are somewhat arbitrary; some PCMH clinics began preparing for the PCMH model as early as the beginning of 2011. As a result, the impact of PCMHs on ED use might have started in 2011, rather than 2012. We also cannot rule out the possibility that clinics selected to participate might have had better infrastructure to serve their patients or had already implemented some PCMH elements before official recognition.



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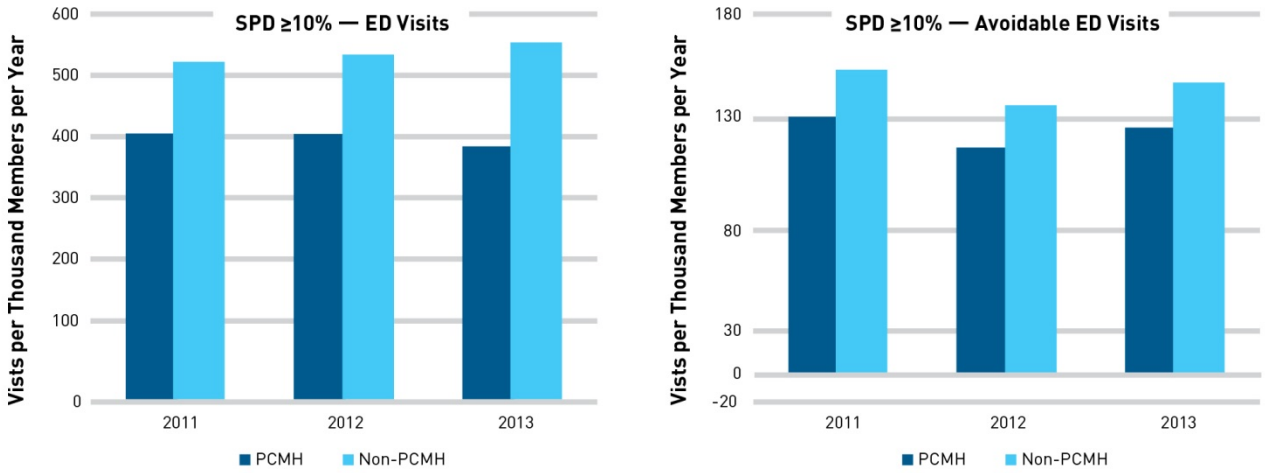
As expected, the PCMH clinics less affected by this transition had better results in reducing both ED and avoidable ED visits, whereas other PCMH clinics receiving more than 10% of SPDs had more consistent rates of ED use in the first year of the post-PCMH period and a minor dip in the second year. Our results suggest a potential crowding-out effect, where the introduction of a new population constrains resources that would otherwise be allocated to the existing non-SPD Medicaid beneficiaries.



Our results from a large urban Medicaid population suggest that a PCMH model in safety net practices can effectively reduce ED use and increase the use of office visits among Medicaid patients.

We will continue to follow up with this PCMH pilot cohort to focus on the impact to the newly transitioned SPD members. The findings support the effectiveness of the PCMH model that avoids ED use, while also revealing the potential limitations of the PCMH model in response to a sudden influx of high-need healthcare users.

Li-Hao Chu is manager of health data analytics at L.A. Care Health Plan; Michael Tu is director of Medi-Cal product administration at L.A. Care; Yuan Chi-Lee is a senior clinical data analyst at L.A. Care; Jennifer N. Sayles, M.D., is chief medical officer of Inland Empire Health Plan; and Neeraj Sood, is professor and vice dean for research at the University of Southern California's Sol Price School of Public Policy and Director of Research at the Leonard D. Schaeffer Center for Health Policy & Economics. A version of this article appeared in the August 2016 issue of the American Journal of Managed Care. *©Managed Care & Healthcare Communications, LLC.*

Medical Homes Aren't Cutting Costs …continued from page 2

The last bit of bad news for PCMH proponents is that the PCMH demos have failed to improve quality of care much or at all. According to the KFF report, "Minimal differences in quality were found between CPC practices and comparison primary care practices, as well as between FQHCs participating in the APCP model compared with FQHCs not participating." Differences in quality between PCMHs and non-PCMHs have not been reported yet for the MAPCP demo.

To sum up, the evaluations of the three PCMH Medicare demos indicate that the "medical home" cannot serve as a viable MACRA APM because there is no evidence yet that it can lower Medicare's costs without harming patients.

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PCMHs Inflict Financial Stress on Doctors

Whether PCMHs can serve as a viable APM will depend not just on whether they save Medicare money, but whether PCMHs raise or lower the revenues of the doctors who "transform" their clinics into PCMHs. If the entities CMS certifies as APMs are less attractive to doctors than the Merit-based Incentive Payment System (MIPS) (the other "track" or compartment within MACRA), doctors are likely to stay out of APMs and hunker down in the MIPS program, regardless of whether the APM in question cuts Medicare's costs.

We need to know, then, how much it costs doctors to set up and run PCMHs.

If we cannot find even crude estimates of PCMH-related costs in the manifestoes of "home" proponents, where might we turn for useful information? You might think the evaluations of the three CMS "home" demos would help, but you'd be wrong.

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Medical Homes Aren't Cutting Costs*...continued from page 2*

The contractors CMS hired to evaluate the CPC and MAPCP demos have made no attempt to determine what costs PCMH clinics incur and whether the revenues clinics receive from CMS offset or exceed those costs. Only RAND, in its evaluation of the FQHC demo, has made that effort, and they struck out. There appear to be two reasons RAND came up empty. The first is the vacuous definition of "medical home." The second is that PCMH clinics are so overwhelmed by the busywork CMS imposes on them they don't have time to determine what the PCMH adventure is costing them.

Common sense and a tiny body of peer-reviewed research tells us PCMHs require clinics to incur substantial costs. A 2015 study in the *Annals of Family Medicine* http://www.annfammed.org/content/13/5/429.full.pdf+html reported the most comprehensive of the two or three useful papers published to date on PCMH costs. The authors concluded that each PCMH physician pays out $105,000 per year for just the "partial implementation" of PCMHs. This estimate did not include start-up costs, lost revenue doctors often experience during and after start-up, the cost of electronic medical records, administrative costs, and other costs attributable to PCMHs.

A 2015 study in the Annals of Family Medicine *...concluded that each PCMH physician pays out $105,000 per year for just the "partial implementation" of PCMHs. This estimate did not include start-up costs, lost revenue doctors often experience during and after start-up, the cost of electronic medical records, administrative costs, and other costs attributable to PCMHs.*

PCMHs Inflict Emotional Stress on Doctors As Well

The evaluation of one of the three PCMH demos contains evidence that setting up and running PCMHs is not merely expensive but also stressful, largely because of the numerous administrative chores CMS imposes on participating clinics.

Although MedPAC was one of the earliest and most influential institutions to jump on the "medical home" bandwagon (they did so in 2008 without offering a shred of evidence for their decision), MedPAC staff and commissioners have expressed disappointment in PCMHs on several occasions in the last two years, based on transcripts of their past meetings.

Medicare's PCMH demos are showing that PCMHs cannot cut Medicare costs and are having little impact on quality; PCMHs are expensive, and are probably costing doctors more than they are getting back in the form of "care management fees" and "shared savings"; and PCMHs can add to the emotional stress that is already at epidemic levels among physicians.

For all these reasons, we may conclude that the PCMH cannot play the role of an APM under MACRA. But that doesn't mean CMS won't force the PCMH (or something quite like it with a new and equally saccharine name) to play that role. CMS is not acting entirely rationally these days. It appears CMS intends to cram the square MACRA peg through the round hole of reality regardless of the consequences.

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Thought Leaders' 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, write to *Medical Home News* Editor Ron Shinkman at RonShinkman@gmail.com.

Q. What role do you think pharmacists and pharmacies can play in patient-centered medical homes and/or related population health initiatives?

"The most frequent interactions with patients is often with pharmacists. Community Care of North Carolina comes to mind here. They operate a medical home for Medicaid patients in that state, and they have a really strong pharmacy perspective. They identify patients for highest risk of (medical complications) through risk stratification. They have pharmacists do reviews of patient records, and focus on the highest utilizers of services. They look at it from a population health perspective. Within a medical home, one of the keys is controlling costs. Pharmacists can play a significant role here, and ensure that we're being proactive rather than reactive."

Charles Lee, M.D.
Founder,
Polyglot Systems
Morrisville, NC

"The pharmacist can play a major role in a successful patient-centered medical home. Coordinated healthcare between different healthcare providers is the best way of achieving better health outcomes. According to the Network for Innovation Health Excellence (NEHI), approximately $290 billion a year is wasted in America on the improper use of medications. As clinically-trained medication experts, pharmacists are best positioned to drive greater adherence. In fact, according to a study conducted by Langer Research Associates on behalf of the National Community Pharmacists Association, the best predictor of patient adherence is their level of personal connection with a pharmacy staff member. In other words, when patients trust and seek the counsel of a pharmacist, they are more likely to maximize their medication regimens.

Patient-centered medical homes are an especially good tool for patients suffering with multiple chronic conditions and complex medication regimens. While the doctor can diagnose the conditions and recommend the right therapy based on their knowledge of medications, it is the highly-accessible pharmacist who can ensure the medication management needs are delivered directly to a specific patient; that an assessment of the specific patient's needs are not being undermined by any drug therapy problems; that a subsequent care plan is developed to resolve any issues that arise; that the care is comprehensive to ensure the impact of all medications on a patient have been taken into account (even over-the-counter medications and supplements); that the care efforts are being coordinated with other members of the patient-centered medical home health team; and that the service is meeting the expectation of adding unique value to the care of the patient.

By handing off this responsibility to pharmacists, the physicians are able to dedicate more time to the diagnostic and treatment selection process, enabling them to be more efficient, see more patients, and spend more time providing medical care. Pharmacists are able to contribute measurable value directly to the care of patients. This occurs because their medication expertise is being utilized to educate patients and minimize interactions and side effects, while recommending drug therapy regimens to physicians and clinicians that move patients more quickly toward clinical goals.

All practicing pharmacists are capable of providing this service. In fact, many pharmacists already provide this type of scalable service and are being paid by federal and state government and private insurers, making this no longer a 'new' or 'non-traditional' service. All that is needed for wider implementation is the appropriate financial and organizational support.."

John Norton
Director of Public Relations
National Community Pharmacists Association
Washington, D.C.

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Thought Leaders' Corner

"We have established a cardiac health program for our recently discharged patients. While it's not a medical home, patients who are considered to be at high risk of readmission do receive closely coordinated care after they're discharged for congestive heart failure or other cardiac ailments. They meet weekly for the first four weeks after discharge with nurse practitioners and other clinicians, including pharmacists. They often receive sound advice from the pharmacists, such as not taking diuretics just before they go to bed, because that will keep them up all night. Patients are also given informational printouts about the drugs they're taking from Lexicomp. As a result, the readmission rates for chronic heart failure patients dropped from 25 percent to about 15 percent over the last 18 months."

Rita Regan
Vice President
South Nassau Communities Hospital
Oceanside, NY

Industry News

HHS.gov
U.S. Department of Health & Human Services

HHS Awards $8.6 Million To Create New Medical Homes, Further Mission Of Existing PCMHs

The U.S. Department of Health and Human Services has awarded more than $8.6 million to 246 health centers to improve the quality of care they deliver through the patient-centered medical home health delivery model. The money was rewarded through the Health Resources and Services Administration (HRSA) Health Center Program. Most of the grants were $35,000 apiece.

"Currently, over 65 percent of health centers have achieved some level of PCMH recognition," said acting HRSA Administrator Jim Macrae. "This funding will help transform even more health centers to be better coordinate care in a way that benefits the patients who need care the most."

The health centers are located in 41 states, the District of Columbia and two U.S. territories: The Federation of Micronesia and the Northern Mariana Islands.

The funding comes from the Affordable Care Act's Community Health Center Fund. That program was extended with last year's passage of the Medicare Access and CHIP Reauthorization Act, commonly known as MACRA.

"These awards will help health centers deliver comprehensive care that puts the patient at the center," said HHS Secretary Sylvia Burwell. "More families in communities around the nation will have access to medical homes where a range of health care needs, including oral health, primary care and behavioral health services, can be coordinated and met."

Officials said the funding would help more than 300 existing health centers achieve recognition as a patient-centered medical home and more than 200 currently certified medical homes continue to optimize their services.

ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

ACP Exec Urges Medical Home Ethos To Include More Patients

A top executive with the American College of Physicians (ACP) believes that more needs to be done to incorporate the ethos of patient-centered medical homes into U.S. healthcare delivery.

Robert B. Doherty, ACP's senior vice president of governmental affairs and public policy argues in an op-ed article in the Philadelphia Inquirer that despite the assimilation of tens of thousands of patients into medical homes over the last decade, many more are being let down by the U.S. healthcare system.

"For all work done over the past decade to incorporate the PCMH principles and the elements of patient-centered care into healthcare delivery, the tragic reality is that too many patients continue to be failed by their encounters with American healthcare," Doherty wrote. He cited the case of Jess Jacobs, who recently died of POTS Syndrome, a rare cardiac disorder.

"(Jess) reported that her primary care physician 'surrendered' her care to other specialists, leading her to ask her primary care physician 'If you are not willing and able to help me, who in your practice is?' She blogged about all of the time she wasted in getting appointments with doctors, by effort involved in trying to coordinate her own care, and in visits that she felt were not at all, or only slightly useful, to her," Doherty wrote.

"We must recommit ourselves to doing everything possible so that we don't surrender patients to a healthcare system that doesn't seem to care about them, and to advocate for reforms to truly put patients at the center of the health care system," he concluded. "This all starts with listening to patients, including those like Jess who now speak to us from the grave."

Industry News

Brooke Army Clinics Receive PCMH Designation

Three clinics operated by the Brooke Army Medical Center at Joint Base San Antonio/Fort Sam Houston in Texas have received patient-centered medical home designation or increased recognition by the NCQA. The general pediatric clinic and adolescent medicine clinic were designated “level 3” medical homes, while the internal medicine clinic was bumped from “level 2” to “level 3.”

“This recognition demonstrates our emphasis on the entire patient and family experience,” said Maj. John Poulin, M.D., chief of Brooke's general pediatric service. “It proves to our beneficiaries that our clinic is recognized as meeting and exceeding national standards of care seen in our civilian counterparts.”

Brooke's adolescent and young adult medicine service is among the largest of its kind in the world. It acts as a patient-centered medical home for patients between the ages of 12 and 25. It is also training nearly 150 residents and students from both military and civilian medical education programs, the largest training site for adolescent subspecialists in the world. The U.S. military has patient-centered medical homes at many of its hospitals at bases on U.S. soil.

Wright State Receives Medical Home Training Grant

Wright State University in Dayton, Ohio has received a $451,764 grant from the Health Resources and Services Administration (HRSA) to train its clinicians to provide services within a patient-centered medical home.

“There are not enough physicians, nurse practitioners or physician assistants to meet the primary care needs of patients,” said Therese Zink, M.D., chair of the family medicine department at Wright State's Boonshoft School of Medicine. “By learning to work together and appreciate each other's scope of practice during training, we will graduate clinicians who are better prepared to work in teams.”

In addition to Wright State's medical school, the grant also pertains to its Miami Valley College of Nursing and Health, the Wright State School of Professional Psychology and the Kettering College Physician Assistant Program.

"The fellowship also will create a pipeline for local health care system leaders," Zink said. "The rapid changes in healthcare delivery and the need to deliver better care and manage costs also are important for health care leaders."

The grant is renewable over five years, officials said.

Catching Up With*…continued from page 12*

How open is the receptionist area is one difference. If the receptionist is behind a desk that's behind a frosted glass window that slides open and shut, that's not a patient-centered medical home. But others have a reception area that is open, and when patients walk in, they're greeted professionally by name, there is minimal involvement in having to register patient, and the patient is familiar with the practice. And how does the nursing staff, the (nurse practitioners), RNs and LPNs, how do they relate to the patient? How does the environment feel?

Medical Home News: *There have been a lot of acquisitions of medical practices by hospitals and healthcare systems as of late. How do you feel that may impact the operation of medical homes?*

David Gans: It's easier to operate a patient-centered medical home in a larger (care delivery) environment like that because the healthcare system will cross-subsidize the primary care. Oftentimes, the acquiring healthcare system sees primary care as an investment as opposed to a revenue center because they see that good primary care reduces costs, and that total cost reduction can be as critical as (the growth of) total revenue. And yes, a patient-centered medical home does cost more to run, and in a hospital system, the expenses are also greater, but some expenses are also assumed by the parent company, such as healthcare IT, and billing can be centralized as opposed to distributed. Some doctors find this arrangement to their benefit. One whose practice was acquired by a larger system told me how thick the rugs and how solid the office doors were compared to when he had to pay for them himself. But the hospital's mission was also being followed and fulfilled as well.

Medical Home News: *Tell us something about yourself we may not know.*

David Gans: I'm retired from the U.S. Army Reserves. I had a 20-year concurrent (to my civilian) career in the military as part of the Medical Service Corps as a hospital executive, where I would spend two to three weeks a year on reserve duty. I spent a lot of time in Korea, which was a challenge, but also made me appreciate the philosophy of ying and yang, and gave me a great perspective on command and mission responsibility. I spent the last three years of my service as the deputy commander of administration at the Tripler Army Medical Center in Honolulu, which is an absolutely beautiful facility. Since the amount of time I would be there was limited, I would normally work on special projects. We would bring in several hundred people and (involve) the staff for special training. We would work on care provision, or an audit of their billing system.

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Catching Up With ...

David N. Gans

David N. Gans serves as the senior fellow of industry affairs for the Medical Group Management Association (MGMA). It's a national trade association representing medical group practices and their leadership throughout the United States. MGMA represents more than 33,000 administrators and executives in 18,000 healthcare organizations where nearly 400,000 physicians practice.

David N. Gans

- Fellow, American College of Medical Practice Executives
- Member, Accreditation Association for Ambulatory Health Care
- Certified Medical Practice Executive
- U.S. Army Reserves Colonel (Retired)
- Master's, healthcare administration, University of Colorado at Denver; Master's, education, University of Southern California; Bachelor's, University of Notre Dame

Medical Home News: *You are the MGMA's point person on patient-centered medical homes. What do you think are their most critical components? And why are medical groups creating them or participating in them?*

David Gans: Some medical groups are driven to create a medical home because to them, a patient having a medical home is the future of primary care. They feel by focusing far more on the patient, it gives them a much more rewarding experience, and it contains all the elements to which a medical practice can play to their strengths, such as good primary care and care coordination. But this comes with a price and cost. There's a recognition that by maintaining that kind of environment, many of those services are not recognized by insurers as warranted for additional compensation. Nevertheless, there are some practices that do see ways that operating a medical home can bring in additional revenue, primarily through incentives offered by some health insurers, as well as additional management fees. And, if they're part of a large organization or an accountable care organization, there may be bonus payments. Also, the feds through the Centers for Medicare & Medicaid Services have demonstration programs, and a lot of groups will participate in them. It still costs more in many instances to operate a medical home than not, but there are positive tradeoffs. Because you're better managing the patient, their disease may not progress, or because of enhanced access in the medical home, they don't need to go to ERs as often, and that can relieve their anxieties and concerns.

Medical Home News: *Startup costs are still a concern for many group practices thinking about creating a medical home. How would you say they are best addressed?*

David Gans: Many people in managed care, they live on a knife's edge of stability. And they look at the conditions and requirements of being a patient-centered medical home, and ask 'can they afford to do that?' I think that's what we hear from a lot of practice administrators. Healthcare is an art, science and a business. They are going to have to be constantly efficient as possible.

Medical Home News: *There are a variety of organizations that accredit patient-centered medical homes (although the NCQA is the leading member of the group). Do you see a winnowing down of requirements or organizations for certification down the line?*

David Gans: I think for the time being the accreditation process for medical homes is stable. There are four different organizations that provide accreditations for medical homes: The NCQA, the Joint Commission, URAC and the AAAHC (Accreditation Association for Ambulatory Health Care). The four programs are different, but there are some commonalities. One of the conditions is to incorporate the joint principles that define a personal physician (itself adapted from guidelines from the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American Osteopathic Association, among others), the patient oriented as a whole person, integrated care, and patient care quality and safety. And there is a pledge toward fostering practice transformation. But how you do all of that may differ.

Some organizations will self-profess or attest, while others go through a much greater extent of certification and recognition. And the third group just lives this day to day. They ask the question about whether you're talking the talk or walking the walk. The ones who are walking the walk, you can tell when you walk into their practice. It's different

(continued on page 11)