

## **NEW DIRECTIONS IN HEALTHCARE: THE COMMONWEALTH FUND PODCAST / SHARING RESOURCES TO SUPPORT MEDICAL HOMES**

*This is New Directions in Healthcare – the Commonwealth Fund’s Podcast, and today we report on an important part of healthcare reform – primary care practices sharing clinical and technical services to become certified medical homes.*

*The idea behind the medical home is to provide patients with comprehensive, coordinated, around-the-clock care; to use support tools like electronic medical records to continuously measure and improve quality; to offer more preventive services and better oversight for chronic conditions; to achieve greater efficiency while reducing errors and costs.*

*To achieve those goals, general, family and pediatric practices must have the right support tools and clinical teams in place, but many will find that difficult or impossible. Melinda Abrams is vice president of the Commonwealth Fund’s patient-centered coordinated care program:*

About two-thirds of primary care is provided in small practices, and most of these small practices have difficulty offering the broad range of services that a medical home must provide, and they often have that difficulty as a result of limited staff, unpredictable demand for service and prohibitive cost. Small practices rarely have money or the volume of patients to employ a care coordinator for example, or employ a full-time data analyst to run quality reports, or a nutritionist to work with their diabetic patients.

*But one in five practices certified by the National Committee for Quality Assurance as a medical home is a solo practice – sometimes meeting requirements by sharing clinical or technical services with other providers. In Denver, for example, 91 percent of pediatric practices have an agreement with the Children’s Hospital to provide urgent care between 5 p.m. and 8 a.m.*

*In Massachusetts, 95% rely on the state-funded Child Psychiatry Access Project for guidance in prescribing drugs and monitoring children with common mental health problems:*

Many of the practitioners, when they were trained, were not trained at a time when many of the medications that are now being used were available. In addition, there are not enough child psychiatrists, therefore many families are asking the pediatricians to manage mental health problems for their children that they weren't trained really to do.

*That's Dr. John Straus, vice president of medical affairs for Massachusetts Behavioral Health Partnership which established the project with six regional teams consisting of a licensed social worker, a care coordinator and a psychiatrist at an academic medical center to support primary care providers. For complex cases, the coordinator can provide referrals, but in most cases the psychiatrist advises pediatricians by phone on the care of kids with attention deficit disorder, anxiety, depression and other common conditions:*

We're there when they need us, so if we give some advice and it doesn't turn out to work exactly as expected, they call up and they say, "What do I do now?" We have a standard that they can get a call back within 30 minutes if not immediately, but certainly within 30 minutes.

*The success of the program can be traced, in part, to the way it was introduced to physicians. Again, Dr. Straus:*

It was very important that the child psychiatrist was going to actually be their consultant – do the calling, that it wasn't an administrative person. It was a doc to doc contact, and really extensive discussion about what we could do. This was not a one-size fits all, force you to do something you weren't comfortable with but was really – what are the things you need? What do we need to know about you?

*At first, Straus says, pediatricians were skeptical:*

A number of them said, "Are you sure this is for free? What's the trick here? Are you sponsored by a drug company?"

*But after three years, regional teams are getting 20,000 calls annually – serving practices that care for nearly 1.5 million children.*

*In New York, a shared technical service also met some resistance at first, but The Primary Care Information Project, established by New York City's*

*Department of Public Health, has now helped more than 2,100 practices to adopt electronic medical records and – by using them -- to improve care.*

There were definitely a cadre of providers who were very excited and thought this was a great opportunity to modernize their practice. Others took a long time to understand -- we weren't there to take their data, and publish it on the front page of the Wall Street Journal or that we weren't turning around and giving their data to payers, and that we were really going to be around for the long haul, that we weren't just a flash in the pan 6-month program that would get de-funded and then leave them out stranded. On average they took about 22 outreach attempts to bring into the project.

*Dr. Amanda Parsons heads the project, which counseled practices on how to secure financial aid through government programs, what hardware and software to buy and how to use it. With electronic records, for example, it's relatively easy to identify at-risk patients:*

A patient who has known hypertension, a history of coronary artery disease, whose last blood pressure was over 160 over 90, the patient hasn't been seen in the last 6 months, and does not have an appointment in the next 3 months. That's a patient that needs action! That's an example of how the provider can go from what we call ***come and get it if you want it*** care to thinking about, "Who are all my patients who need to be seen, and how do I ensure that everybody who needs an appointment or who needs a refill or who needs a reminder actually gets one?"

*But many small practices said they didn't have anyone who could make calls or send letters to patients who needed follow-up care:*

And we said, "What if we could hire people and train them to use the electronic medical record and then embed them at practices?" That panel manager could work one day a week at each of five practices and could run the reports and call patients back, and we've had great success with our initial pilot of this project. We did this pilot at three different practices. Over 60 percent of patients who were reached out to by this panel manager actually came back in for care and if you think about it, y'know you get a reminder from your mechanic that your car needs an oil change. You get a reminder from your OB/GYN, from your dentist, but you rarely get a reminder from a primary care provider.

*In light of this preliminary success, the Primary Care Information Project plans to expand the service to 20 more practices and to study the impact in greater detail.*

*New York City now has the largest community electronic health record in the nation and was recently designated a regional extension center by Department for Health and Humans Services— one of sixty that Melinda Abrams says are patterned after agricultural extension programs.*

There's this hub that will help funnel lessons learned from other states or other countries and send agents out into the field, whether it's to farms or here to primary care practices -- to kind of get them to test new innovations.

*In this capacity, New York hopes to help another 4,600 practices add electronic record keeping over the next two years. Funding will come from local, state and federal government programs and from not-for-profit organizations. Dr. Parsons notes that insurance companies were also asked to support this outreach, but most declined – even though they could benefit financially:*

Many studies have shown that the savings from health IT do not accrue to the provider who purchased the hardware. They actually accrue to the patients and to the payers.

*On the other hand, there will be more funding for shared services as the Patient Protection and Affordable Care Act of 2010 is implemented. It strongly promotes the **medical home** concept through incentives and pilot programs. Thirty-seven states are already planning or implementing pilots in their Medicaid or CHIP programs, and at least 26 commercial plans are testing the medical home model.*

*At the Commonwealth Fund, Melinda Abrams says medical homes – made possible in many cases by shared services – are having a positive impact on primary care overall:*

The early evidence shows that it's improving quality as well as also saving money. We see a reduction in emergency department use and unnecessary hospitalization. We also see, from a study out of Group Health Cooperative in Seattle, Washington, that clinicians and staff are more satisfied with their jobs, and since we have a workforce problem and a primary care workforce

crisis in this country, anything also to try to attract more clinicians into primary care is also promising.

*But to support and fuel this trend, Dr. Edward Schor, the Commonwealth Fund's vice president for state health policy, warns that shared services must respect the central role of physicians in patient care, and where clinical services are involved, be established locally:*

Having relationships established is really important. Physicians don't really like to send patients + to someone that they don't know, whose quality of care they're not comfortable with, and so having things local, having people know one another at least at some level, is important. On the other hand, some services don't require that kind of relationship. There's some pretty good experience, for example, with nurse *warm lines* that practices have used. They're available 24 hours a day, and patients from anywhere in the country can call for advice. Now the physicians are comfortable with that only when they get a sense of what was told to the patients, so they don't want to be left out of the loop.

*To learn more about the potential of shared resources to improve care while reducing costs, see the article co-authored by Melinda Abrams, Edward Schor and Stephen Schoenbaum in the June issue of Health Affairs. You've been listening to New Directions in Healthcare, the Commonwealth Fund Podcast. I'm Sandy Hausman.*