

LHS MEDICAL HOME

A STATUS REPORT
JUNE 2009

ORIGINS

- 1967 AAP Standards of Child Health Care: “Medical Home”

Hospitalization of medically fragile children drop from 58% to 43%

- 1996 Institute of Medicine
Committee on the Future of Primary Care

- 1998 North Carolina Medicaid
Community Care of North Carolina

Saved state Medicaid \$60 million in 2003 and \$120 million in 2004

- 2004 Institute of Medicine
Crossing the Quality Chasm: A New Health
System for the 21st Century

ORIGINS CONTINUED

- 2004 AAFP, ABFP, STFM, ADFM, NAPCRG, AFMRD, AAFP Foundation
 - *The Future of Family Medicine Project*
- July 2006 AAFP, ACP
 - *Joint Principles of the Patient-Centered Medical Home*
- March 5, 2007 AAFP, AAP, ACP, AOA
 - *Joint Principles of the Patient-Centered Medical Home*

JOINT PRINCIPLES

1. Personal physician – for first contact, continuous and comprehensive care
2. Physician directed medical practice – physician-led team who collectively render care
3. Whole person orientation – personal physician takes responsibility for providing and arranging to be provided for acute and chronic needs
4. Care is coordinated and /or integrated – all elements of health care system and community are organized to assure care provided appropriately in terms of being timely, culturally and linguistically appropriate

JOINT PRINCIPLES CONT

5. Quality and safety

- Optimal outcomes
- Evidence-based medicine
- Quality improvement measures
- Patients included in decision-making
- Information technology utilized
- Certification of actual “medical home”
- Patients and families included in QI

6. Enhanced access – appointments, phone, internet

JOINT PRINCIPLES CONT

7. Payment

- Reflect value of non-face-to-face work
- Include coordination of care expenses
- Support technology acquisition and use
- Support enhanced communications
- Recognize the value of remote monitoring
- Allow for separate fee-for-service payments for face-to-face visits
- Reflect case mix differences in the patient population being treated
- Reward physicians for savings from reduced hospitalizations
- Reward additional payments for achieving quality improvements

Why did it happen here?

- Administration
- Physician interest and dissatisfaction with present healthcare system
- New EMR – adding patients, improved records, untapped capabilities
- Limited patient population
- Devoted patient population



Lakewood
HEALTH SYSTEM

YOUR HOME
for healthcare.

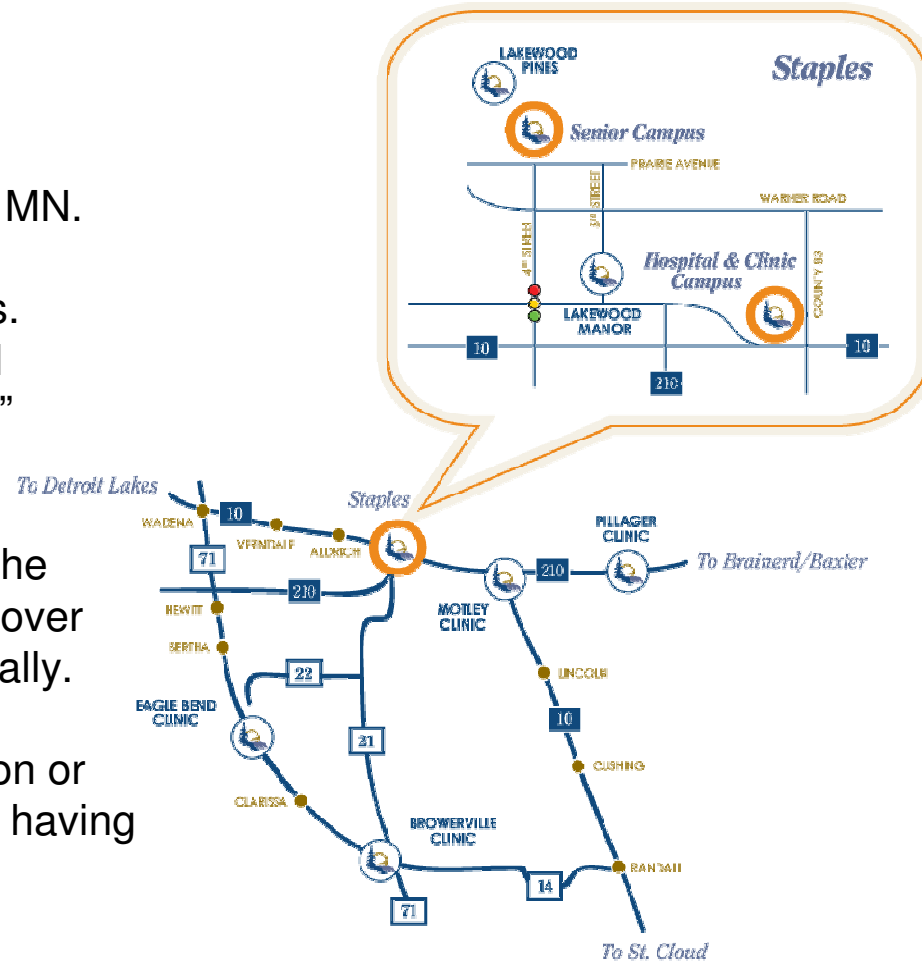
LAKEWOOD HEALTH SYSTEM

- Community Served

Lakewood Health System's (LHS) Main Campus is located in Staples, MN. LHS is within three miles of the boundaries of four different counties. All of these counties are considered some of the poorest and the "oldest" (age of residents) in the state.

The area's growth rate is slow and the already large proportion of persons over 50 is expected to increase dramatically.

We do not and will not let our location or circumstances be an excuse for not having the best care available.



LAKEWOOD HEALTH SYSTEM

- System Components

HOSPITAL

CLINICS

Staples, Motley, Pillager, Browerville, Eagle Bend

SENIOR SERVICES

Care Center, Memory Care, Lakewood Pines, Lakewood Manor, Lakewood Reflections, Home Care, Hospice, Palliative Care

FOUNDATION

RETAIL

Shoppe, Medical Marketplace (DME)

SOULSTIS MED SPA

Laser Skin Care, Injectables, Cosmetics

LAKEWOOD HEALTH SYSTEM

- **Recent Accomplishments**

90% Press Ganey customer satisfaction scores

Gallup employee engagement scores increased from 36% to 60% in three years

Increase in gross patient revenue from \$61M to \$107M in three years

Recruitment of 12 physicians (doubling medical staff in three years)

Best Rural Minnesota Workplace

One of only two hospitals to achieve all four Minnesota safety initiatives

19 out of 20 stars CMS care center rating

National Rural Health Team Award from Health Leaders Media

Who are the patients

CRITERIA FOR MEDICAL HOME PATIENT ADMISSION

- **Multiple diagnoses (3 or more requiring treatment)**
- **Multiple medications (4 or more prescriptions)**
- **Severe illness**
- **Chronic illness(diabetes, CHF, etc)**
- **Illness requiring frequent visits (every 2 months or less)**
- **Lack of insight into health care (due to age or intelligence)**
- **Physician identifies “good candidate”**
- **Patient request**
- **Patient must be willing to follow-up with a single provider to routine cares**

What do they get

BENEFITS OF MEDICAL HOME ADMISSION:

- Coordination of care with consultants
- Efficient care
- Informed inclusion in healthcare decisions
- Personal contribution to records
- Education about the specific personal medical problems
- General preventative medicine education
- Reminders of needed preventative medicine testing
- Maximum utilization of latest guidelines/recommendations

What do they get: continued

BENEFITS OF MEDICAL HOME ADMISSION CONTINUED:

- Reminders of appointments and tests
- Priority access to a specific nurse and doctor
- Availability of a nurse care coordinator
- “Team” concepts of physical therapy, occupational therapy, pharmacy, dietary and other specific service providers
- Encouragement to live healthier through education, reminders and group activities
- Impetus to help in the development of disease-specific preventative and therapeutic programs

Medical Home Team Members

- Medical Home Physicians
- Individual physician nurses
- Medical Home Care Coordinator
- Medical Home System Coordinator
- Medical Home Physician Supervisors
- Medical Home Pharmacist
- Independent pharmacists
- Medical Home Information Technologists
- Social service
- Physical therapists
- Dieticians
- Diabetic educators
- Occupational therapists
- Medical consultants
- Billing/coding experts
- Communications experts
- Exercise therapists

How far are we

What we do know:

- System works – enabling primary care provider time and contact for patients
- Patients like it – able to get answers and help, reassured they are being taken care of
- Physicians like it able to spend effective amount of time with complicated patients; care coordinator able to effectively answer questions and triage
- Urgent care is busy and stable
- System is consistent with important new developments in Minnesota (Health Care Homes)

How far are we: continued

What we don't know:

- Will it provide better outcomes
- Will it be financially feasible
- Will physicians continue to be willing to provide the extra time and communication
- How long will it take for the “electronic world” to come to our area and thereby reduce some of the costs
- Will the numbers of patients grow beyond our ability to provide the promised care or will we be able to grow fast enough to keep up

What is the enrollment process

- **Patient, family, consultant or other health care provider** contacts LHS and the care coordinator, who then requests endorsement from the patient's primary care provider, verifies the record, educates the patient, sends materials and enters the patient into the Medical Home classification listing.
- **LHS computer review or a third party** such as pharmacy or insurer identify a patient as a candidate. The care coordinator is notified who then requests endorsement from the patient's primary care provider, verifies the record, educates the patient and sends materials to the patient. The patient is then entered into the Medical Home classification listing.
- **Provider initiates enrollment**

What does a provider need to do

INTERNAL PROCESS OF MEDICAL HOME PATIENT ADMISSION

- Ideally primary care provider sees patient in the clinic, identifies that patient as a good candidate, discusses “Medical Home” with the patient, finds out any additional information needed (such as last PSA, colonoscopy, etc), gives him/her an updated copy of the “Medical Home Summary” in the plastic folder, sends the other copy of the updated “Medical Home Summary” sheet to Niki, our Medical Home Care Coordinator.
- Primary care provider identifies a patient not in the clinic as a suitable Medical Home patient, prints out the Medical Home Summary, updates if he has time, and sends the Summary to Niki.

System Coordinator

- Reviews chart for suitability
- Reviews chart for accuracy and completeness, calling patient if extra info needed (such as last PSA, mammogram, pap, colonoscopy), then enters any new info not already entered
- Compiles a listing of Medical Home patients and updates this weekly
- Identifies all Medical Home patients on the EMR
- Generates disease/med specific lists of Medical Home patients for letters according to the Screening Protocol
- Answers calls from Medical Home patients for correction of EMR

Care Coordinator

- Answers phone and e-mail questions from Medical Home patients
- Corrects and completes records including all preventative care categories upon admission to Medical Home using EMR or patient telephone calls
- Develops lists of appropriate patients for Medical Home, gets permission from the provider involved, telephones patient to verify data on the record, sends the patient the updated Medical Home Summary
- Sends “Welcome to Medical Home” letter to all new Medical Home patients
- Develops, with System Coordinator, lists of Medical Home patients with specific diseases for disease specific letters
- Arranges consultations and allied healthcare
- Is innovative in concepts of preventive and therapeutic cares for chronic disease, especially activities, and education in group sessions.
- Compiles a list of all Medical Home patients and updates weekly

Physician Supervisors

- Follows-up the Screening Protocol for accuracy, changes and ideas for improvement
- Evaluates individual medical home physician utilization of the system
- Assists care coordinator with medical home patients when their own physician not available
- Reviews Quality Improvement data for system and individual providers
- Reviews appropriate notification for screening protocols
- Evaluates and responds to opportunities and needs of the system for changes and improvements
- “Champions” the medical home amongst providers, administration and public

Welcome to Your Medical Home

Welcome to your MEDICAL HOME

WHAT IS A MEDICAL HOME?

Medical Home is a new way of providing medical care that gives you the extra attention needed to ensure the best of medical care for your personal health. It more effectively manages your medical care so that you don't wait until you are sick to see your doctor. Medical Home is intended to **decrease your cost of healthcare by keeping you healthier.**

WHY AM I A PART OF IT?

Your doctor has identified you as being among the people most likely to benefit from this added service. Patients are identified as Medical Home patients when they have multiple medications, multiple illnesses or an unstable illness.

WHAT WILL BE DIFFERENT?

Your Medical Home Provider is the same doctor you have been seeing regularly in the past, but now you will also have priority access to a Medical Home nurse and your doctor through e-mail and telephone. Your doctor will coordinate the care you receive from Lakewood Health System and from other hospitals, specialists and medical services you may use. In addition to this priority access, your care is fully coordinated to include reminders, extra education and regular contact with the Medical Home nurse to ensure that you receive customized, proactive care.

DOES IT COST MORE?

There are no additional charges to either you or your insurer. Lakewood Health System has put in computerized medical records, which enables us to provide this service without any extra cost to you.

WHAT DO I DO NOW?

You can expect a call from the Medical Home nurse to help explain this new care. Your obligation as a Medical Home Patient is to **keep your Medical Home Summary** with you for all healthcare appointments, and to **let your Medical Home Provider know about any medication or treatment changes recommended elsewhere.**

We hope that you will see it as an improvement of an old way of practicing medicine using the newest of technologies. Above all, we want you to feel that Lakewood Health System is your true **home for your healthcare.**



NO-COST BENEFITS

- Decreased healthcare costs by keeping you healthier
- Appointment reminders
- Follow-up reminders
- Self-care training
- Added education
- Eligible for group testing programs
- All of your healthcare is actively coordinated by Lakewood Health System
 - specialist appointments
 - changes in medication
 - other services
- Priority e-mail and phone access to medical home nurse and your doctor

"Lakewood Clinic has developed a new, markedly expanded service to help us ensure that we deliver the best medical care especially for those patients needing extra attention.

Welcome!"

JOHN HALFEN M.D.
Lakewood Health System
Medical Director

djhalfen@lakewoodhealthsystem.com

Routine of Medical Home Screenings

Monthly:

- Patients with 10 or more medications without MTM in past year
- Patients not seen within past 6 months
- Patients turning 65 (Welcome to Medicare Exam)
- Males turning 65 with history of any smoking and no abdominal ultrasound

Annual:

- “Medical Home Patient Screening Protocol”
- “Medical Home Screening Calendar”

MEDICAL HOME PATIENT SCREENING PROTOCOL

1. Based upon PQRI.
2. Based upon U.S. Preventative Services Task Force 2006 Guidelines.
3. Based upon Nursing Home Standards.
4. Based upon Common Practice.

Based upon PQRI:

- hemoglobin A1C >9
- diabetes with LDL >100
- CHF without ARB or ACE inhibitor
- CAD without ASA or Plavix
- CAD + previous MI without beta blocker
- CVA or TIA without carotid Doppler
- CVA or TIA without ASA or Plavix
- women >65 without bone densitometry
- osteoporosis without bone resorption inhibitor
- history of hip or spinal fracture without bone densitometry
- diabetes without RX for shoes
- BMI greater than 30 or less than 22 without dietary consult
- history of breast cancer without selective estrogen receptor modulator

Based upon PQRI: Continued

- prescriptions for PPI or H2 blocker without diagnosis or GERD or PUD
- prescription for PPI or H2 blocker + osteoporosis
- diagnosis of hepatitis C without viral studies
- >50 without influenza vaccine within 1 year
- >65 without Pneumovax
- CAD +DM or CHF without ACE inhibitor or ARB
- diabetes without urine microalbumin
- chronic kidney disease without ACE inhibitor or ARB
- chronic kidney disease without creatinine, calcium and lipid profile within 1 year
- chronic kidney disease without blood pressure reading within 1 year

Based upon U.S. Preventative Services Task Force 2006 Guidelines:

- hypertension or hyperlipidemia without blood glucose
- lipid profile within 5 years
- male + smoking history + 65-75 without abdominal ultrasound (aneurysm)
- coronary artery disease without ASA
- >50 without colonoscopy within 10 years
- women <65 without pap smear within 2 years
- women <80 without mammogram within 2 years

Based upon nursing home standards

- weight change >10% in past year
- 10 or more medications
- psychotropics without psychotic disorder and without reduction within 6 months

Based upon common practice

- males 50-70 without PSA within 2 years
- women on PPI or H2 blocker for >2 years without bone densitometry
- diabetic on thiazide diuretic
- COPD without Pneumovax
- CAD without HMG Co-A reductase inhibitor

The MH Calendar

September 2008							September 2008							October 2008													
							S	M	T	W	T	F	S								S	M	T	W	T	F	S
September 1								1	2	3	4	5	6								5	6	7	8	9	10	11
Diabetes+LDL>100								8	9	10	11	12	13								12	13	14	15	16	17	18
																					19	20	21	22	23	24	25
8								16	17	18	19	20	21								26	27	28	29	30	31	
CHF without ARB or Ace inhibitor																											
15																											
Previous MI without beta blocker																											
22																											
CVA/TIA without Carotid doppler																											
29																											
CVA/TIA without ASA Or plavix																											

Results of previous screenings

1. Proton Pump inhibitor with a DX of osteoporosis

Total patients 338

8 patients – chart alerted

2. Hypertension/hyperlipidemia without BG in past year

Total patients 420

30 patients – chart alerted

3. CVA/TIA without ASA or Plavix

Total patients 420

7 patients - chart alerted

4. Hip/spine FX without a Dexa scan

Total patients 279

3 patients – chart alerted

5. BMI <22 without dietary consult

Total patients 317

9 patients – chart alerted

6. Chronic renal disease without ARB or Ace Inhibitor

Total patients 367

3 patients – chart alerted

7. Diabetics with HGB A1C over 9

Total patients 180

4 patients – chart alerted

Results of previous screenings cont:

8. Diabetics with HGB A1C over 9

Total patients 378

1 patient – chart alerted

9. Diabetes and no Hgb A1C in the last 6 months

Total patients 199

15 patients – chart alerted

10. Heart failure with NSAID use

Total patients 418

6 patients – chart alerted

11. Diabetes + LDL>100

Total patients 214

21 patients – chart alerted

12. Diabetes + LDL>100

Total patients 380

3 patients – chart alerted

13. CAD/CHF without Ace Inhibitor or ARB

Total patients 360

3 patients – chart alerted

Lakewood Health System Medical Home Consultation Request

This patient has a “**Medical Home**” established at **Lakewood Health System**. This is a concept by which our patients and their providers maintain accurate and complete communication enabling effective comprehensive cares. Our providers take the responsibility to manage all aspects of our patients’ healthcare.

You are being provided with the summary sheet including diagnoses, medications, allergies and preventative care information in order for you to be more aware of this patient’s overall health status. If you have requested other records or the consulting physician has thought them pertinent, they also are included here. Should you need further records please call us at 218-894-1515 and we will provide that information promptly.

Please let the physician requesting this consult as well as the patient’s listed primary care provider know as soon as possible of your opinions and any changes you make in the care and diagnoses. Our providers wish to continue in the care and decision-making processes as much as practically possible.

Thank you for becoming a part of the “team” working together with this patient to provide the most appropriate healthcare possible.

Lakewood Health System Medical Home Consultation Request

Page 2

John Halfen M.D.
Lakewood Health System
49725 County Road 83
Staples, MN 56479
218-864-1515
drjohnhalfen@lakewoodhealthsystem.com

Date of this information: _____
Patient Name: _____
Birthdate: _____
Telephone Number: _____

For **Current Diagnosis, Current Medications, Current Allergies** and **Directives**, please see the **Patient Electronic Chart Summary/Medical Home Summary** included with this consultation request.

For recent **laboratory** and **radiologic reports** and **pertinent previous consults**, please see accompanying data.

Reason for the consult:

Please:

- Evaluate and Recommend Treatment
 Evaluate and Treat as Deemed Appropriate
 Please assume care

Thank you for your assistance with this patient!

John P. Halfen M.D.

Pharmacy coordination

- Consultations – Medical Home Pharmacist
- MTM – Medical Home Pharmacist
- Team member – Medical Home Pharmacist, patient's personal pharmacist
- Refills – patient's personal pharmacist

What is the organizational structure

1. Medical Home Physician Supervisors develop the system and supervise all implementation of the principles following closely the “Joint Principles”.
2. Medical Home Physicians provide the extra care, time and availability to the patient with the assistance of the Medical Home Care Coordinator.
3. LHS through the Physician Committee consisting of all employed and contracted physicians approves the structure and functioning of the Medical Home.
4. LHS Board through the President of the System approves the structure and function as well as the financial functioning of the Medical Home.
5. Medical Home Care Coordinator follows the established guidelines for reviews, supervises individual non-primary care provider patient contacts, coordinates overall care and develops reports.
6. Marketing works with the Coordinating Physicians and Care Coordinator to develop program brochures for patients and for physicians.

Why is it working here

- Primary care base
- “Devoted”, confined population
- Urgent Care
- Progressive administration

How will we know if it is working

- Hospitalizations
- PQRI
- Patient surveys
- Number of cases found on the “searches”
- Financial reports
- MQIC
- Bridges to Excellence
- NCQA

IDEAL EVIDENCE

- Mortality
 - relativity makes it hard to verify
- Disability
- Happiness (not health)
- Hospitalizations
- Need for healthcare interventions (medication, therapy, etc.)

OUR EVIDENCE

- Centricity – specific goals
- MQIC
 - Bridges to Excellence
 - PQRI
 - NCQA
- Physician satisfaction

OUR FINDINGS – JUNE 2009

MQIC

NCQA DPRP 2006 Measures

- **HbA1c<7.0%**

Criteria	40%
Consortium	50.91%
Lakewood	56.77%
- **HbA1c>9.0%**

Criteria	15%
Consortium	19.76%
Lakewood	15.90%

OUR FINDINGS – DPRP (cont)

- **BP<140/90**

Criteria	35%
Consortium	70.11%
Lakewood	64.47%

- **BP<130/80**

Criteria	25%
Consortium	38.26%
Lakewood	35.40%

OUR FINDINGS – DPRP (cont)

- **Complete Lipid Profile**

Criteria	85%
Consortium	88.36%
Lakewood	86.21%

- **LDL < 130**

Criteria	63%
Consortium	83.44%
Lakewood	79.87%

- **LDL < 100**

Criteria	36%
Consortium	68.82%
Lakewood	68.32%

OUR FINDINGS – DPRP (cont)

- **Nephropathy Assessment**

Criteria	80%
Consortium	67.40%
Lakewood	58.50%

- **Others not able to be accurately assessed**

1. Smoking Status and Cessation Advice
2. Eye Examination
3. Foot Examination

OUR FINDINGS – DPRP - Individuals

- 1409832352000600 - 274 visits with 29 complete
HbA1c>9 – 7.4%; BP<140/80 – 58.62% ; LDL<100 – 81.81%
- 1440412613000930 – 271 visits with 28 complete
HbA1c>9 – 0% ; BP<140/80 – 53.57% ; LDL<100 – 52.63%
- 1409833082000600 – 102 visits with 7 complete
HbA1c>9 – 28.57%; BP<140/80 – 57.14%; LDL<100 -50%
- 1414916734000610 – 58 visits with 14 complete
HbA1c>9 – 0%; BP<140/80 – 57.14% ; LDL<100 – 76.92%
- 1441209362000970 – 2 visits with 1 complete
HbA1c>9 – 0% ; BP<140/80 – 100% ; LDL<100 – 100%
- 1434883168000830 – 2 visits with 0 complete
HbA1c>9 – 0%; BP<140/80 – 0% ; LDL<100 – 0%
- 1414322730000620 – 1 visit with 0 complete
HbA1c>9 - 0%; BP<140/80 - 0%; LDL<100 - 0%
- 1441268527000710 – 1 visit with 0 complete
HbA1c>9 – 0%; BP<140/80 – 0% ; LDL<100 - 0%
- 1414917800000610 – 1 visit with 0 complete
HbA1c>9 - 100%; BP<140/80 – 0%; LDL<100 – 100%

How can it earn money

- Increased coding due to increased time and attention
- Quality reporting – PQRI for now (not Rural Health Clinics)
- Marketing of services resulting in more reliable and engaged patients
- Increased efficiency of Urgent Care with a “Medical Home” follow up
- Increased efficiency of hospitalization and consultation requests
- Primary care providers seeing known patients with reliable follow-ups, known payment history, and not having to see unreliable, unknown patients as often
- Possible reimbursement for care management
- Competitive advantage over other area providers.

What are the non-monetary costs

- Development time from a “champion” who must be trusted by the staff and administration
- Devotion to the primary care provider as the lead player in the healthcare system
- Change from episodic reviews and evaluations based upon specific diseases to the entire patient’s care
- Development of a two-tiered office system for primary care itself: Urgent Care and Medical Home

Where do we go next

- Expand definitions of appropriate patients
- Increase primary care providers
- Go back to the most difficult problems and try again with new endeavors (eg obesity)
- PHR
- More education endeavors
- Develop interface system with other care coordinated programs such as hospice and urgent care

How can others make this work - Rural

1. Find a champion
2. Enlist the entire medical staff in support of the “Joint Principles”
3. Possess a “good” electronic medical record system
4. Get unconditional administrative support financially
5. Look at the working systems such as ours at LHS and translate into a relevant system
6. Identify the patient population desired to be within the Medical Home and make sure they are able and willing to be consistently managed (they must be trusting of their provider)

How can others make this work - Urban

- Same as rural but the final factor is more difficult
- Be competitive with other area providers in the service offered but with respect for medical homes established by others
- Follow the “Joint Principles” very closely and point out when other medical homes may be deficient (an approved state/federal certification may be needed)

OTHER ATTEMPTS

Meritcare – Fargo – Blue Cross/Blue Shield 2004-2007

1. RIGHT MOVES

- Care Coordination – RN
- Comprehensive care and guidelines with evidence based medicine
- Primary care physician
- Electronic health record
- Improved communication
- Patient education and empowerment

2. RESULTS

compare Main Clinic with Medical Home started in 2004 vs other clinic with start in 2006

- Improved care

- Cost reduction

2006 annual global medical cost reduction to BC/BS of North Dakota 42%

- Decreased emergency room visits

2006 ER utilization visits/100 patients: 20.79 in MH Clinic vs 33.63 in other clinic

2007 With MH in both clinics: 23.42 vs 30.19

3. WRONG MOVES

- Did not deal with the totality of patient problems, only diabetes, hypertension and coronary disease
- Put the care into the hands of an RN instead of the physician (based premises on the prevention of increase time/effort by the MD)
- Selected a population likely to show success – only 55-65

TransforMED

- Important demonstration projects started in 2006
- Based upon the “Joint Principles”
- Self-directed are 18 of the 36 – others “facilitated”
- Await further reports
- 24-month design

OTHERS

- New York state pilot projects
- North Carolina
- Special needs children
- Alaska: “SCF Model” – Southcentral Foundation
- OregonCare
- Group Health - Seattle

OregonCare – SCF Model

- **Payor initiated** - FQHC plus Commonwealth Fund
- “escape the tyranny of one-on-one with provider, **team-based** rather than primary care provider-based
- pilot projects of 2007 are now “**struggling**”
- “**flexible**” **standards** instead of NCQA standards
- **triage nurses** becoming care managers
- improved outcomes in two of five pilot clinics
- no identification of those in more need
- itinerant populations

Group Health Seattle

- Partial NCQA
- Providers like (given decreased panels and longer office visits with good patient response but plan to get back to increased panels)
- No new system for provider use
- No care planning and no patient councils
- “We avoid use of the medical home terminology as patients don’t understand.” (think it is nursing home or home care)
- Emphasize electronic communications as means of saving money

MINNESOTA – HEALTH CARE HOMES

- Legitimate
- Responsible
- Workable
- Appropriate
- Promising
- **Needs** vocal, enthusiastic, devoted **support**
- Only constructive criticism

Helpful Directions of Medical Homes

- Self-supporting with rewards; not subsidized
 - Learn from the Pediatric Medical Home Initiative of the Minnesota Children with Special Health Needs program.
- Certification
 - National Committee for Quality Assurance (NCQA)
 - Inadequate in asserting physician-led
 - “Uses paper or electronic-based charting tools to organize clinical information.”
 - “Adopts and implements evidence-based guidelines for three conditions.”
 - “Joint Principles” need to be adhered to tightly or improved but NOT degraded
- Encouragement from the legislatures, insurers and consumers, eg Bridges to Excellence Programs
- Electronic compatibility between practices, insurers, certifiers, hospitals, home care, long term care and EHR's (only will occur with federal mandates)
- Clarify the roles of providers to prevent duplication and enable Medical Home development
- National education initiative to prevent care overuse, duplication and thereby prevent less than anticipated results.

What needs to be changed

- Provisions allowing the “personal clinician” to be a physician assistant or advanced practice nurse.
- Idea that all people should be under the “medical home” umbrella instead of just the more needy.
- Advancement of the “urgent care” concept in order to develop a primary and secondary level of care system.
- Any allowances for “paper” charts and reporting as this just costs the entire system money and slows down practical conversion.

What do we need

- Primary care physicians, mid-levels for urgent care
- Interoperable systems
- Coordinated health care system
- Recognition of non-face-to-face expenses

What else do we want at LHS

- Endorsement of our method
- Interoperability and portability
- PHR consistency
- Financial support for non-face-to-face work and supportive services expenses
- Outcomes-based financial support and other incentives in a Rural Health Clinic setting
- Healthcare system basic changes

Is this the new healthcare? - what else is needed

- Emphasis on preventative
- Emphasis on noninvasive
- Prevention of overuse
- Fast track approvals of “Medical Homes”
- Population education re: proper expectations, antibiotic uses, “nutritional supplements”, DTC advertising
- Pharmaceutical limitations
- Penalties for false claims and advertising