

## TASK FORCE FUNCTIONS

- **MISSION INTEGRATION**  
Transformation of clinical care, education, and outcomes research
- **INFORMATION CLEARINGHOUSE**  
Information distillation to ADFM membership
- **STRIKE FORCE**  
Proactive leadership to shape policy and influence change among key stakeholders

### Inside this issue:

CMS Demonstration Project for Advanced Primary Care	....2
Center for Employer Engagement	....2
Report re: Regional Extension Programs	....3
Stories from the Field:	
• Medical Student Curriculum	....3
• Community Engagement	....4
Members in the Press	....5
Legislative Committee: Health Care Reform provisions relevant to PCC	....5
Linking PCMH to Patient Centered Research	....6

## NCQA Publishes draft of new Medical Home Criteria

*Public comment period open until June 28, 2010*

The National Committee on Quality Assurance has just released draft guideline revisions for 2011, with a June 28th deadline for comments – *ADFM members are encouraged to review and comment during public comment period.*

The PCMH 2011 standards build on the strengths of PPC-PCMH. They apply to the full spectrum of practice configurations, from small to large or electronically enabled to paper-based, in a variety of practice locations and for newly applying practices, as well as for those seeking renewal of Recognition. In addition to emphasizing patient-centric, coordinated care and moving toward

performance benchmarking within practices, the revised standards seek to:

- Encourage better integration across practices through enhanced quality improvement requirements
- Strengthen program requirements
- Integrate behaviors affecting substance abuse and mental health issues
- Align with the Centers for Medicare & Medicaid Services' proposed Measures of Meaningful Use (for ARRA incentives)

The program has been restructured from nine standards (in PPC-PCMH) to six standards. We propose additional advanced requirements: reporting standardized clinical and

patient experience results and establishing formal relationships with specialists and facilities. As with the current program, NCQA will not require all items to be met for achieving Recognition.

NCQA invites all parties to comment on proposed changes to the Physician Practice Connections®-Patient-Centered Medical Home™ (PPC®-PCMHTM) 2011 standards from May 27-June 28.

<http://www.ncqa.org/tabid/1196/Default.aspx>

For more information on public comment, contact NCQA Customer Support at 888-275-7585.

## NDP Report Now Available

*Carlos Jaen*

Here at last! The long awaited final evaluation report of the AAFP's National Demonstration Project (AKA TransforMED's NDP) will be available on line at <http://www.annfammed.org/> Monday June 7, after 5PM EST. The issue includes 8 peer-reviewed articles detailing the context, methods to evaluate PCMH changes, description of the intervention, narrative of

practice journeys, effect of facilitation on practice outcomes, patient outcomes, a new primary care practice development approach, and a summary article with key findings and implications. As a bonus the issue also includes extensive online appendices with copies of instruments.

A limited number of printed copies are avail-

able, if you or your faculty want to get copies please send an email and the number of copies request to [Gorham@uthscsa.edu](mailto:Gorham@uthscsa.edu) and make sure you include a mailing address. Along with the release of the issue you are invited to participate in the On Track discussion of specific issues and/or the overall issue. Thank you for your patience.

## CMS Demonstration Project for Advanced Primary Care Just Released

*PCMH Task Force Co-Chairs, Libby Baxley and Tony Kuzel to be featured as plenary speakers at the December 2010 STFM Practice Improvement Conference – look for announcements soon!*

CMS just announced its Multi-payer Advanced Primary Care Initiative last week, with a short turn around time for Letters of Intent (June 17, 2010) and application submission (August 3, 2010). Under this demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and

efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas.

For more information about the demonstration and a copy of the application requirements, see the demonstration web site: <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1230016>

States conducting multi-payer APC initiatives are eligible to apply for the demonstration. To qualify for participation, the initiatives:

- Must be conducted under state auspices;
- Have promotion of the APC model as its central purpose;
- Include Medicaid and substantial participation by private health plans;
- Have substantial support by primary care providers;
- Include mechanisms for community support of participating practices; and
- Be coordinated with state health promotion and disease prevention efforts.

The results of the National Demonstration Project are presented in a special issue of *Annals of Family Medicine* in May 2010 -

Available at: [http://www.annfam.org/content/vol8/Suppl\\_1/index.shtml](http://www.annfam.org/content/vol8/Suppl_1/index.shtml)

*Participate in the “on track” discussion!*

## Brief Report on the Center for Employer Engagement

*Allen Perkins*

The PCPCC Center for Employer Engagement has worked mainly to showcase stories of success in which employers have tried the PCMH model and found it delivers on their expectations. The group has produced a document, Value Based Purchasing, that educates employers about the principles and promise of the PCMH, and provides real-life examples of companies (and, in some cases, entire state governments) that have chosen to use this model to improve access and

outcomes and reduce costs. The nut that has yet to be cracked is how to engage employers who are not self-insured, because there is a general belief that one must find new money to prime the pump of the PCMH through enhanced reimbursements for population care and care coordination, and the economic climate makes that particularly difficult. This conundrum is reminiscent of the state of affairs on Capitol Hill, where legislators from both parties readily embrace primary

care and the PCMH, but are politically unable to either find new resources (read, taxes) or redirect existing resources (read, taking from the haves to give to the have nots). Pilot projects are the natural response to this sort of dilemma, and are important, but we all might benefit from other practical strategies. Any bright ideas from ADFM members that we can bring to the table are most appreciated.

## Report re: Regional Extension Programs

*Kevin Grumbach*

The ARRA funded HIT Regional Extension Program's (REC) emphasis on achieving meaningful use brings the extension program into close alignment with what we had all along envisioned for a primary care extension program. The meaningful use criteria require not just installing and turning on an EMR, but engaging in a practice improvement and redesign process with HIT being the tool to get at much more fundamental changes in

the entire practice model. Family Medicine departments need to be aware that the ONC has now approved the state RECs and the funding is starting – ***Chairs are encouraged to try to develop collaborative relationships with the HIT RECs and advertise their assets as a resource for collaborating on practice improvement in primary care.*** At a minimum, we should realize that many of us will be eligible as providers for ARRA HIT money.

Family Medicine departments may already be part of the REC process and are centrally involved in setting up some of the RECs – we would love to hear your stories. The RECs have potential to morph into the type of primary care extension program envisioned in the reform bill (the ARRA HIT REC funding is only a 2 year proposition), and we should be at the table in our states!

### PCMH at the STFM Annual Spring Conference

PCMH had a very strong presence at the STFM Annual Spring Conference with one of the four General Sessions focused on PCMH. Additionally, there were a large number of educational and research presentations devoted to patient-centered care, medical homes, and PCMH, including:

- 16 Roundtable Presentations of Scholarly Activity
- 15 Seminars
- 28 Lecture-Discussions
- 32 Peer Papers (completed and in-progress)
- 27 Research Posters

Access the conference brochure and handouts at: <http://stfm.org/conferences/pastbrochures.cfm>

Access PowerPoints and other resources in the Family Medicine Digital Resources Library at: <http://www.fmdrl.org>

## Stories from the Field: Medical Student Curriculum

*Andrea Manyon; Story from Chris Matson at EVMS*

We started developing the teaching tool we call the Electronic Health Record Laboratory (EHRL) in 2009 using WebSP software, the tracking software used within our Theresa A Thomas Professional Skills Teaching and Assessment Center (Gayle Gliva, director). The basic EHR allows populating simulated patient histories, learner entering of data collected from interviews and exams of simulated patient, and medical decision-making, including ordering of laboratory tests, imaging studies or consults, and accessing point-of-care electronic resources. Results of orders can be provided

on follow-up visits. Details of learner/patient interaction is recorded using video technique with multiple cameras, including a robotic camera that follows facial details; and tracking software that monitors all keyed entries. Learner entries can be graded using WebSP key word programming, for review by course director. The EHRL will be used as a research tool for investigating the interaction of using an EHRL, effectiveness of the patient interview, and the doctor-patient relationship. It will be used as an assessment and teaching tool assessing residents' skills, including challeng-

ing patients of all types, with combined immediate feedback from simulated patients and analysis of progress notes. It will be used as part of the simulation of a patient-centered medical home based in a community health center, including assessment and improvement of cultural competence and patient-centered interviewing, by our clerkship director, Dr Bruce Britton. The EHRL bypasses privacy issues and proprietary restrictions of EHR vendors, and creates an electronic and video record of the entire patient visit.



Image from AAFP: [http://www.aafp.org/online/etc/medialib/aafp\\_org/images/news\\_folder/aafp\\_news\\_now/2009-6/pcmh-house.Par.0001.Image.250.gif](http://www.aafp.org/online/etc/medialib/aafp_org/images/news_folder/aafp_news_now/2009-6/pcmh-house.Par.0001.Image.250.gif)

## Stories from the Field: Community Engagement

*Rich Wender, MD and Lloyd Michener, MD*

### For further reading, some news from other disciplines:

#### *Patient-Centered Medical Homes: The Path Forward*

The present and future of the patient-centered medical home (PCMH) model of primary care is explored in depth in the **June issue of the *Journal of General Internal Medicine***. In a series of articles written with support from The Commonwealth Fund, the Agency for Healthcare Research and Quality, and the American Board of Internal Medicine Foundation, leading researchers and thought leaders discuss the key issues that need to be resolved if the PCMH is to gain wider currency in U.S. primary care.

#### **Greater NIH Investment in Family Medicine Would Help Both Achieve Their Missions**

“Family medicine is the predominant provider of primary health care in the United States, yet it receives relatively little research funding from the National Institutes of Health (NIH). Family medicine can help the NIH speed research discovery and improve research rel-

The Patient Centered Medical Home is a powerful care model with the potential to dramatically improve health care for all, including population groups that traditionally face poorer health outcomes. Of critical importance to realizing this potential is accepting the fact that the major causes of morbidity and mortality (tobacco use, over-eating, lack of physical activity, and violence) cannot be managed exclusively within the confines of a medical office. Furthermore, for many individuals with chronic illnesses, environmental and community factors are important determinants of how patients choose to, and are able to, manage their health. One of the most important, most difficult, but most satisfying aspects of the PCMH is the opportunity to build partnerships with communities that can extend the reach of the medical home to those locations where patients actually live and make daily health choices. Health care

evance; the NIH can help family medicine build its research capacity, and such mutual benefit could mean improvement in public health.”

See Graham Center One-pager #64 at <http://www.aafp.org/afp/2010/0315/p704.html>

reform has generated new opportunities to build and financially support these partnerships.

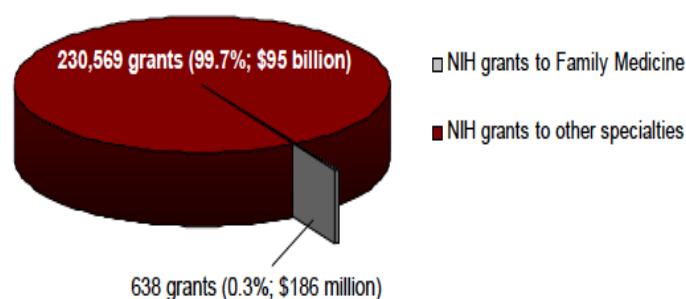
For instance, The Wellness Center in Philadelphia is a partnership between Project Home, an extraordinary community based organization in the heart of North Philadelphia, and Thomas Jefferson University. Project Home and Jefferson’s Department of Family and Community Medicine, in partnership with dental and mental health professionals and the YMCA, will pilot a new way to integrate recreation, food availability, navigation, education, and health care for some of Philadelphia’s most vulnerable citizens, including chronically homeless individuals. Support for this model is enhanced through innovative payment models from multiple insurers.

In Durham, North Carolina, a broad-based coalition is seeking to improve the health of all who live in

the county, building on the practice redesign already underway in the primary care offices (led by the Duke Family Medicine Center). Care coordination programs for Medicaid and the uninsured, managed by the Department, now extend to include all practices and over 100 community agencies and groups. Coalitions such as this one could become the basis of the next generation of health care redesign – the health care innovation zone - which seeks to learn how to more effectively connect and use health resources between medical groups and their communities.

Here is the take home lesson: The public and private health care market is ready to embrace innovative models that link communities with primary care. The PCMH can be the bridge between public health, community engagement, and health care delivery.

**Figure: NIH Grants to Family Medicine Compared with Other Specialties**



## Members in the Press:

Al Tallia's article, Academic Health Centers as Accountable Care Organizations, in the May issue of *Academic Medicine* is a must read! Written with the dean and health system CEO at UMDNJ, Tallia's concluding sentence is "By fostering discovery, learning, and care through rational organizational structures that meet the needs of populations and bend the curve of growing health care expenditures, AHCs can lead health care reform in the 21st century."

Al writes: "My hope is departments across the country can use the rationale outlined in the piece to play significant leadership roles in changing AHCs. Here at Robert Wood Johnson, for the past nine

months I've been engaged in the conceptualization and development of our new ACO, Robert Wood Johnson Partners. Having met with just about every stakeholder in the New Jersey healthcare ecosystem, I would offer you all the following insights of many about ACO development:

1) Academic health centers are in excellent positions, particularly if they have in some way supported primary care and community initiatives in the past, to be seen as 'trusted' agents i.e. not just being in it for the money.

2) Direct conversations with employers/payors about their needs and wants from the healthcare system, and the needs and wants of their employees

are most fruitful and can bring other stakeholders to the table and engender cooperation.

3) The shortage of primary care, while clearly bad for our country, is an advantage departments can use as leverage points in our own local environments."

*Response from Libby Baxley:* I have used Al's article several times in the past couple of weeks with my health systems leaders who are working on ACO development – it has helped our discussions along nicely – thanks, Al, for being the first to contribute to the literature on the ACO/PCMH link within academic health center. You are helping me already!

## Legislative committee:

### Health Care Reform (HCR) provisions relevant to PCPCC

*Mary Hall, MD, ADFM Representative to PCPCC Legislative Committee*

The committee is pulling together pieces of the HCR law that are relevant to the work of the PCPCC. This is meant to be a living document tracking the features of HCR that relate to PCMH and informing our action items. We are working on a system to prioritize the regulatory items to address and are starting where the money is! Two areas that will receive our immediate attention are strategies for PCMH demonstration projects (Title III) and provisions related to primary care payment (Title V). As we move forward in this process in review of the issues on the list, the group is asking:

- a) Is this an issue within the purposes and ambitions of PCPCC?
- b) What is the priority of the issue?
- c) Are we trying to monitor the issue or influence the issue?
- d) Is it useful to have a position and is there relative consensus?
- e) If there is a position what type of request do we have: changes in statute, funding, regulatory interpretation or rulemaking, demonstration or pilot design or criteria
- f) What are the means for monitoring or influencing? Meetings, Letters, Comment on HHS Budget, Letter to Appropriations, Comment Periods

## PCPCC Legislative Committee Goals:

1) Support payment, coverage and other policies that promote primary care and improve the patient-centered medical home as a means to transform delivery of care.

2) Support piloting of medical homes, ideally through multi-payer piloting, including through federal programs such as Medicare and Medicaid, to include broad patient participation and full transformation of practices.

3) Develop technical assistance programs to support primary care and patient centered medical home practice transformation, such as primary care extension programs.

4) Support primary care workforce training and professional development, including by:

- (a) increased funding for National Health Service Corps Scholarship and Loan Repayment Programs;
- (b) expanding and focusing federal support in programs under Title VII and Title VIII of the Public Health Service Act to better prepare primary care health professionals to provide patient-centered care;
- (c) additional pathways for scholarships and loan forgiveness programs to create incentives for careers in primary care; and,
- (d) reforms to Medicare GME to further promote primary care training.



## Linking PCMH to Patient Centered Research

Lloyd Michener

*Ideas for future newsletters? Contact Libby Baxley at libby.baxley@uscmed.sc.edu*

One large but complex area for the PCMH efforts is linking to parallel efforts underway in patient-centered research at NIH, AHRQ and CDC; and with the larger health care demonstrations authorized by the new legislation, such as health care innovation zones. Perhaps the most important point is that there ARE parallel efforts, and that analyses are being discussed that would permit studies of the relative value of the different

elements of the medical home model, and of the incremental value of different 'clustering' of the elements, for different populations. These analyses will require large studies across multiple regions, and may support 'networks of networks' to allow for adequate size and power. See the IOM list of priorities for comparative effectiveness research at: <http://www.iom.edu/~media/Files/Report%20>

[Files/2009/ComparativeEffectivenessResearchPriorities/Stand%20Alone%20List%20of%20100%20CER%20Priorities%20-%20for%20web.ashx](http://www.iom.edu/~media/Files/Report%20Files/2009/ComparativeEffectivenessResearchPriorities/Stand%20Alone%20List%20of%20100%20CER%20Priorities%20-%20for%20web.ashx)

More information on health care innovation zones can be found in The Healthcare Innovation Zone - A Platform for True Reform. Kirch DG, *JAMA*. 2010;303(9):874-875

### Task Force Members and Areas of Interest Related to PCMH

AHC: Clinical Care		Policy	
AAFP Clinical Commission	Jeff Susman	PCPCC Executive Committee (monthly, Tues. 4-5:30 EST)	Libby Baxley, Ardis Davis, Jeff Borkan, (Rich Wender - back up)
Extension Service	Kevin Grumbach	PCPCC Legislative Committee (biweekly, Thurs. 3 PM EST)	Kevin Grumbach, Mary Hall
CFHA	Rusty Kallenburg	PCPCC Center for Multistakeholder Demonstration (biweekly, Tues. 2 PM EST)	
NCQA / revisions task force	Carlos Jaén, Frank deGruy	PCPCC Center for Employer Engagement (biweekly, Wed. 3 PM EST)	Tony Kuzel
CMS Demonstration Projects	Will Miller	PCPCC Center to promote Public Payer Implementation (monthly, Tues. 3PM EST)	
ADFM Clinical Committee	Dave Schneider	PCPCC Center for Consumer Engagement (monthly, Fri. 10 AM)	David Schneider
AHC: Education		PCPCC Center for eHealth Information Adoption and Exchange (monthly, Thurs. 1 PM EST)	Mary Hall
STFM	Allen Perkins, Mary Hall	PCPCC Task Force on Care Coordination and the PCMH (biweekly, Wed. at 4 PM; starts 4/14)	Jeff Susman
AFMRD	Alan David	PCPCC Task Force on Mobile Health Communication and Technology (biweekly, Thurs. 2 PM EST, 4/22, 5/6, 5/20, 6/3, 6/17)	
AAMC / HIZs	Lloyd Michener, Barb Thompson	PCPCC Integrating Behavioral Health into the PCMH (biweekly, Thurs. 10 AM EST, 4/22, 5/6, 5/20, 6/3, 6/17)	Jeff Susman
HRSA; other GME reform	Allen Perkins	ADFM Legislative Affairs Committee	Mary Hall, Kevin Grumbach
RRC-FP	Mike Magill		
ADFM Residency Education Committee	Alan David		
ADFM Medical Student Education Committee	Andrea Manyon		
ABFM	Warren Newton		
AHC: Research			
NAPCRG	Tony Kuzel		
AHRQ			
NIH / CTSA	Lloyd Michener		
CDC	Lloyd Michener		
ADFM Research Committee	Paul James		