

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

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Educational Joint Principles of the PCMH Now Approved

The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association have published a new policy to guide the education of medical students in an era of health care reform that promotes preventive health services and a greater reliance on primary care. The policy, known as the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home, builds on the Joint Principles of the Patient-Centered Medical Home, which the groups adopted three years ago. The principles have also been endorsed by the Patient-Centered Primary Care Collaborative. According to Perry Pugno, the new principles are an important guide to medical schools to place emphasis on prevention and the need for increasing access to primary care: "Training for PCMH practice has been embraced by the graduate medical education community, but at the medical school level, the response has been less -- hence, the development of these principles to guide development at the medical school

level of training." The new medical education principles relate each of the original PCMH components to the pertinent Accreditation Council for Graduate Medical Education/American Board of Medical Specialties core competencies and describe the corresponding education subprinciples.

- For example, the personal physician component of the PCMH joint principles calls for each patient to have an ongoing relationship with a personal physician trained to provide first-contact, continuous and comprehensive care.
- The corresponding education subprinciples say that medical students are expected to experience continuity in relationships with patients in a longitudinal fashion within practices that deliver first-contact, comprehensive, integrated, coordinated, high-quality and affordable care. In addition, students are expected to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families and fellow professionals.

- Student attributes/competencies related to physician-directed, team-based practice say that medical students should be able to demonstrate collaborative care via leadership skills that result in effective information exchange and teaming with patients, their patients' families and professional associates.
- The educational subprinciples also call for medical students able to work effectively with others as a member or leader of a health care team; articulate the roles, functions and working relationships of all members of the team; and apply knowledge of leadership development, quality improvement, change management and conflict management.

The new joint principles acknowledge that integrating these features into undergraduate medical education will require additional resources. In some cases, students simply can be incorporated into existing patient-care and practice-based activities. In other cases, however, additional faculty -- such as those with expertise in economics,

health policy or business administration -- and staff will be needed to create and oversee new experiences for the students. "We know that the current model of health care isn't financially sustainable," said Pugno. "We need at least some medical schools and their academic medical centers to show leadership and make some difficult choices -- and change how they do business. In the short term, it will cost, but the dividends will come in the future."

The medical education principles also point out

that preparing faculty for health reform changes as a prerequisite to training medical students in both primary and specialty care is an "unmet need." Accordingly, the principles call for demonstration projects to help inform decisions about faculty development methods, as well as the development of assessment tools and outcomes measures. They also state that resident physicians will be "integral components" of medical student education in PCMH concepts.

According to Pugno, medical schools have had mixed

results in preparing physicians to practice in the new environment. "I believe the nation's medical schools are making a valiant effort to respond to all of the competing needs for training tomorrow's physicians," he said. "Some seem to be doing better than others. But many are still rooted in the old, narrow specialty and hospital-centric model of care. The joint principles were created to assist schools in evolving their curricula forward to meet future needs."

Educational Joint Principles available at:

http://www.aafp.org/online/etc/medialib/aafp_org/documents/news_pubs/ann/joint-principles-for-med-ed.Par.0001.File.dat/PCMH-educ-joint-principles-120710.PDF

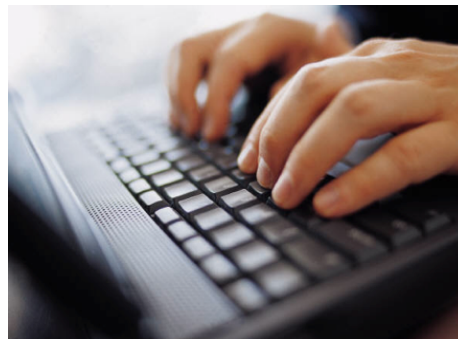
ADFM PCMH Taskforce Pilot Webinar - Brief Report

Ardis Davis, MSW

On January 7, 2011, the ADFM PCMH Taskforce held a pilot webinar which was opened up to all Chairs and Administrators who are members of ADFM. The webinar lasted 60 minutes and featured a presentation by Lloyd Michener, MD on "The Medical Home at Duke". Twenty-eight participants, including 16 chairs, 1 administrator and 11 others (designees of chairs or individuals joining with a chair) joined the webinar. A number of chairs asked for the session to be recorded for asynchronous viewing. Below are brief comments on content and process.

Content: There was universal expression of great ap-

preciation for the content presented by Lloyd Michener including a number of follow-up e-mails to learn more about the topic. Having someone experienced with presenting webinars



(such as Lloyd) was very helpful to orient participants to both the technical logistics of participation in the webinar and the content of the presentation.

Process: Prior to the we-

binar, Ardis Davis worked very briefly with Paul Ford, IT staff in the University of Washington Family Medicine Residency Network (UWFMRN) office, and staff in Lloyd Michener's office

to ascertain readiness for the webinar. Adobe Connect Classroom platform was used to host the webinar. The UWFMRN pays annually for one Adobe Connect classroom (\$330 annually). The actual cost of the webinar was the cost

of approximately 3.5 cents per line per minute – costing roughly about \$60 to put on the webinar. There were no technical glitches noted regarding participants being able to access the webinar, hear the dis-

If you missed the webinar (The Medical Home at Duke" by Lloyd Michener) and want to view it, access it at:

<http://uofw.na4.acrobat.com/p96058787/>

discussion, view the slides or follow the discussion. The webinar was recorded and the URL for accessing the URL asynchronously was made available to all ADFM members.

Next steps: The ADFM Taskforce is exploring feasibility of conducting one more webinar before the Winter meeting in Charleston. Future directions for this kind of activity will be explored by the PCMH

Taskforce and by Board taskforces on revenue generation and governance.



More than half of members attending the ADFM fall meeting reported having NCQA PCMH recognition

Report from November PCMH Task Force Meeting

Sixteen members of the PCMH Taskforce met on November 6 following the ADFM Fall meeting in Washington, D.C. Those present were given an outline of potential issues to discuss and, following this, a set of strategies was agreed upon, including:

- Collecting information on Educational pilots /stories/ successes related to the PCMH to provide members with ideas on how to approach transforming curriculum to match practice redesign changes. A survey process, led by Alan David, was developed and will be analyzed and presented to ADFM Board and membership. *This survey was conducted, with rich data from over 60 depts indicating a range of involvement in education around PCMH. The TF will be reviewing the results of the data at the Winter meeting.*

- Communicating to ADFM members about up-and-coming information and resources, such as CMS guidelines for ACOs and the AAMC Readiness for Reform program, through newsletters and the listserv.
- Encouraging Task Force members to consider authorships of key editorials, policy papers, etc.
- Piloting a webinar, to foster information transfer and some interactive components between departments who participate. *A report on the pilot webinar is on page 2 of this newsletter.*
- Working more on defining the research aspects of this work – e.g. better understanding variation, best practices, creating new evidence on what works for the future.

Following discussion at the November 6 meeting, the

ADFM Board Governance and Revenue Task Forces are addressing these related issues:

- Considering development of a PCMH consultative process – to dispatch members who can consult with schools/departments who wish to have help in their teaching practice and educational transformation.
- Expansion of Task Force focus to considering how the PCMH fits into the larger anticipated system changes (ACOs, Medical Neighborhoods), in order to help members lead this type of change in their own systems
- Combining ADFM Clinical Committee with ADFM PCMH Task Force – TF mission would remain broad, to also include education, research integration, but would gain participation of Clinical Committee members.

NCQA PCMH 2011 Vision

- *Multiple performance levels*
- *Streamline documentation; renewal process*
- *Raise bar on scoring*
- *Focus medical home links to outcomes (quality, patient experience, cost)*
- *Move toward / facilitate performance benchmarking*
- *Embed meaningful use*

Berwick Launches Initiatives That Mobilize Primary Care

“For too long, health care in the United States has been fragmented-failing to meet patients’ basic needs, and leaving both patients and providers frustrated. Payment systems often fail to reward providers for coordinating care and keeping their patients healthy reinforcing this fragmentation. The Innovation Center will help change this trend by identifying, supporting, and evaluating models of care that both improve the quality of care patients receive and lower costs.”
-- Donald Berwick, M.D., CMS Administrator.

Eight states have been selected as pilot sites for a CMS initiative that will allow Medicare to join Medicaid and private insurers in state-based efforts to improve the way health care is delivered: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. These advanced primary care model sites were selected for their potential to improve health care value, enhance patient care and give primary care providers better information about their patients, including evaluating the effectiveness of the care system working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans. The Multi-Payer Advanced Primary Care Practice Demonstration will ultimately include over 1,200 medical homes serving almost one million Medicare beneficiaries.

Additionally, Don Berwick recently announced the launch of the new CMS Innovation Center, which will examine new ways of delivering health care and paying health care providers that will save money for Medicare and Medicaid while improving the quality of care. The center will focus on new models of care, such as the patient centered medical home and accountable care organizations, to test their

impact on both quality and the success of new payment models.

The Center will also test models that include establishing an “open innovation community” that serves as an information clearinghouse of best practices in health care innovation. They will work with stakeholders to create learning communities that help other providers rapidly implement these new care models.

Other new initiatives on the horizon will test “health home” and “medical home” concepts:

- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration will test the effectiveness of doctors and other health professionals working in teams to treat low-income patients at community health centers. The demonstration will be conducted by the Innovation Center in up to 500 FQHCs and provide patient-centered, coordinated care to approximately 195,000 people with Medicare.
- A new State plan option under which patients enrolled in Medicaid with at least two chronic conditions can designate a provid-

er as a “health home” that would help coordinate treatments for the patient. States that implement this option will receive enhanced financial resources from the Federal government to support “health homes” in their Medicaid programs.

- The Innovation Center also announced an upcoming opportunity for States to apply for contracts to support development of new models aimed at improving care quality, care coordination, cost-effectiveness, and overall experience of beneficiaries who are eligible for both Medicare and Medicaid, also known as “dual eligibles.” The Innovation Center expects to award up to \$1 million in design contracts to as many as 15 state programs for this work. In addition, the Innovation Center will support two additional dual eligible health care integration demonstrations that will be announced in 2011 and will focus on the role of providers and beneficiaries, respectively.

More information on these initiatives is available at: innovation.cms.gov

New Updated Report on PCMH Evidence

Kevin Grumbach and Paul Grundy have issued an updated version of their review that looks at evaluations of outcomes of various PCMH initiatives. The new version has many updated findings and new case studies, including some great data from the VA. The findings are very impressive in terms of the triple aims of better quality,

better patient experience, and lower costs.

From Kevin: "The evidence is accumulating nicely on the beneficial outcomes—including net savings from the investment in better primary care. The request to update the original report came from the staff at PCPCC for information to use in the briefing by

Don Berwick and Kathleen Sebelius where the multi-stakeholder PCMH initiatives were announced by CMS."

Feel free to share with anyone who might find this of interest. http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

Employer Focus on PCMH

In late October, seven large employers, including six Fortune 500 companies and one state, officially launched Catalyst for Payment Reform. CPR is an effort to help the largest employers work together to accelerate reforms in how we pay for health care

in the U.S. The employers, including The Boeing Company, DeltaAir Lines, Equity Healthcare, GE, the Group Insurance Commission of the Commonwealth of Massachusetts, Intel Corporation, and Wal-Mart Stores, Inc., have agreed to advocate for health care

payment approaches that reduce costs and waste while spurring higher quality and to work to put such payments in place with the health insurance plans with which they contract. <http://www.catalyzepaymentreform.org/>

PCPCC Annual Spring meeting

PCMH: A Foundation for Transformation and Reform, will be held March 30, 2011 at the Ronald Reagan Building in Washington, DC. Elliott Fisher, from the Dartmouth Institute, will be the keynote speaker, and many other offerings of interest to ADFM members will occur during the day. For more details, see <http://www.pcpcc.net/event/meeting/3-30-2011>

NCQA has a pair of conferences in the spring that might be of interest to ADFM members:

<http://www.medicalhomesummit.com/registration.php>

Third National Medical Home Summit A Hybrid Conference, Internet and Training Event March 14 - 16, 2011 | Philadelphia, PA

The 2011 Medical Home Summit will feature national keynote addresses and plenary session discussions on medical home transformation, ACOs and employer interest, as well as nine "Mini Summits" on key medical home issues. The 2011 event will also offer two preconferences - an Advanced Medical Home Boot Camp highlighting key implementation issues and a preconference on clinical integration and clinical workflow to improve outcomes in chronic diseases. Early bird rates end January 7.

How to Facilitate Patient-Centered Medical Home Recognition: A Hands-On Approach and Analysis Through NCQA's Eyes March 17 - 18, 2011, Philadelphia, PA

Expert faculty from NCQA will guide participants in this interactive workshop on the updated PCMH Recognition program. We will examine how practices can demonstrate that they meet NCQA's PCMH requirements and discuss sample submissions for PCMH Recognition. Participants will learn how to identify documentation that does (and does not) meet the requirements and practice scoring each element. The group will identify strategies for enhancing and improving valid content and clarity of the application toward a recognized patient-centered medical home.

ACO UPDATES

The PCMH model is commonly being discussed in relation to ACO movement these days – as a necessary foundational component of an accountable care organization. Many health systems are recognizing their “primary care vulnerability,” and many Family Medicine Chairs are being asked by their Deans and health system leaders to provide leadership in this area. The

ADFM Annual Meeting will feature discussions to help prepare members for answering that call to help develop starting points for many emerging ACOs. One future model that is being proposed is The Patient Centered Accountable Care Organization, which would include: a network of PCMHs; PCMH Neighbors – our specialty colleagues (see ACP position paper,

Oct 2010); patient-centered hospital(s); pharmacies; labs; insurers and data to effectively manage care across the spectrum. It will be interesting to see how this all evolves and to help shape the process in our academic health centers and states. Meanwhile, a number of groups are getting on the ACO with their own proposed criteria:

NCQA Criteria for ACOs

The National Committee for Quality Assurance released draft standards for accountable care organizations last fall; the draft was available for public comment

through mid-November on NCQA’s website. Proposed standards addressed topics including ACO structure, resource stewardship, availability of practitioners, data

collection and integration, population health management and quality improvement. Final standards have not yet been released.

AMA Releases ACO Principles

The American Medical Association’s recently released ACO principles state that “Accountable Care Organizations must be physician-led, patient-centric and ensure voluntary participation from patients

and physicians.” Moreover, federal and state anti-kickback and self-referral laws, and the federal Civil Monetary Penalties statute, need to be flexible. Existing antitrust and fraud rules can make becoming

part of an ACO difficult for physicians, especially those in small practices, the AMA warns. <http://www.healthleadersmedia.com/content/LED-258973/AMA-Releases-ACO-Guideline%23%23#%23>

PCPCC working with members to launch new ACO Center

The Patient-Centered Primary Care Collaborative (PCPCC) is working with members to launch a new Accountable Care Organization (ACO) Center. The new Center will play a key role in ensuring that, as ACO’s move forward, they do so with a strong, robust patient-centered primary care model at their core. Patient-centered primary care must be central and foundational to any ACO, and the new Center will serve

as an important forum for building consensus on how to realize this fundamental objective. The new Center will also serve as a bridge between ACO learning centers, collaboratives, pilots and demonstration projects and the PCPCC. The new ACO Center will be a much-needed voice advancing the idea that robust, effective and contemporary primary care must be integrated into the ACO. There are four co-chairs of the

ACO Center – representing Family Medicine is Ted Epperly, MD, the Program Director and C.E.O. of the Family Medicine Residency of Idaho, Boise, Idaho. Ted is a Clinical Professor of Family and Community Medicine at the University of Washington School of Medicine and is the former President and Chairman of the Board of the American Academy of Family Physicians.



CMS Criteria for ACOs

CMS is viewing both the PCMH and ACOs as joint strategies for delivery system reform. Kevin Grumbach participated in a Sept 8th meeting organized by the PCPCC that brought

Elliott Fisher, PCPCC leaders, health plan execs, and others together to forge a more well articulated alliance between the ACO and PCMH movements. The summary report from Sept

8 is being finalized and PCMH Task Force will get this information out to all ADFM members as soon as it is available.

Joint Principles for ACOs

The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) have released "Joint Principles for Accountable Care Organizations."

administrative structure of ACOs, as well as how payment should be facilitated. The four organizations developed the principles through an extensive collaborative process to reflect those attributes they believe are essential for the effective implementation of the ACO model within the health care system. The principles state that primary care should be the

foundation of any ACO and that the recognized patient and/or family-centered medical home is the model that all ACOs should adopt for building their primary care base.

The new joint principles define key characteristics of effective accountable care organizations. The principles include:

The 21 principles describe important aspects to consider when building the

ACO Joint Principles available at:

http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/private/healthplans/payment/acos/20101117.Par.0001.File.tmp/AAFP-ACO-Principles-2010.pdf

Structure of the ACO

- They provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population they serve.
- They demonstrate strong leadership among physicians and other health care professionals.
- Organizational relationships and all relevant clinical, legal, and administrative processes within ACOs are clearly defined and transparent.
- They include processes for patient and/or family panel input in relevant policy development and decision making.
- They include a commitment to improving the health of the population served through programs and services that address needs identified by the community.
- They provide incentives for patient and/or family engagement in their health and wellness.
- Participation by physicians, other healthcare professionals, and patients/families is voluntary.
- Nationally-accepted, reliable and validated clinical measures are used to measure performance and efficiency and evaluate patient experience.
- They implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination.
- Barriers to small practice participation are addressed and eliminated.
- They are adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
- They promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families they serve

Payment

- The payment models and incentives implemented align mutual accountability at all levels.
- The payment models and incentives implemented adequately reflect the relative contributions of participating physicians and other health care professionals.
- The payment models used recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
- Recognition and rewards for the ACO's performance are based on processes that combine achievement relative to set target levels of performance.
- Practices participating within ACOs that achieve recognition as medical homes by NCQA or other nationally accepted certification entities should receive additional financial incentives.
- The structure adequately protects ACO physicians and other health care professional participants from "insurance risk."
- They employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs.

Stories from the Field: PCMH Educational Transformation in the Army FM Programs

Terry Newton, MD, FAAFP, Chief of Primary Care, Martin Army Community Hospital

Martin Army Community Hospital is the Army's largest MEDDAC. We proudly train approximately 21 Army Family Practice Residents every year. Our Family Medicine Residency program is supported by a large Family Medicine Clinic that supports over 21,000 beneficiaries. In the summer of 2009 we began an ambitious effort to transform our clinic into a patient centered medical home (PCMH) model of healthcare delivery. This effort has required monumental changes in the culture, business practices, and information tools in our Family Medical Home clinic. As a deliberate part of this transformation we have involved the Family Medicine residents in both formal and informal ways.

We periodically present didactic sessions explaining the concepts of PCMH and had the president of TransforMed, Terry McGeeney, speak to our residents in 2009. We redesigned our longitudinal curriculum to

include a two week PGY II block and a two week PGY III block. In the PGY II year our residents spend time with our medical home champion discussing the concepts of PCMH. The resident is required to do a formal reading program and research current issue in PCMH using key web sites such as the Patient Centered Primary Care Collaborative (PCPCC) and TransforMed. The resident is then required to write a one page summary of their findings. The concept of continuous process improved is taught and the resident is required to perform a Process Improvement (PI) project. Often these projects are part of their PCMH team and focus on improving processes within their team. During the PGY III year the resident shadows key leaders in the PCMH to include the clinic OIC/Manager and the Chief of the Department. The resident receives direct observational experience in the daily issues involved in transforming a large clinic

into the PCMH model.

Informally, our residents are part of our clinic transformation. They attend monthly meetings with their PCMH team and are directly involved in team building and continuous PI. The residents participate daily in team huddles and work directly with their team nurses to provide longitudinal care even when they are not scheduled to be in the clinic. Our Family Medical Home clinic is an advanced access clinic with 2/3rds of our appointments as same-day appointments. This academic year we began an initiative to assign our interns to clinic one hour daily (when not on in-patient services) in lieu of the traditional half day a week clinic in an effort to foster the fundamental concept of the PCMH which is establishing a strong physician-patient relationship through continuity of care, team-based care, and improved access to care.

Harvard Medical School Launches \$30 Million Center for Primary Care

Harvard Medical School announced the launching of a new Center for Primary Care, a center of excellence geared toward transforming primary care education, research and delivery systems. Made possible by a \$30 million anonymous gift, the Center, will have physical and virtual dimensions, serving as both a physical and intellectual docking point for students, residents, fellows and faculty from across HMS and its distinguished affiliated teaching hospitals. To learn more: http://hms.harvard.edu/public/news/2010/102810_primary_care/index.html

PCPCC Training the Workforce Task Force

In recent years, the issue of training the primary care workforces in the PCMH has become an increasingly popular topic. The PCPCC has recently approved a Training the Workforce Taskforce, housed in the Center to Promote Public Payer Implementation, which will be tasked with developing a framework outlining training opportunities associated with health professions schools, graduate medical education and fellowships. The Taskforce will address potential solutions to workforce training issues through:

- Professional schools programs selecting, supporting, and train-

ing PCMH-ready clinicians

- Team work/interdisciplinary training
- Life-long learning of key skills to all clinical groups
- Linked payment reform

Taskforce Items and Proposed Plans:

- Identify Industry Experts - The taskforce will work to identify and reach out to the leading industry experts on this topic area. We will attempt to integrate them, their knowledge and experience in with the work we are doing.
- Construct a database

of future Taskforce call speakers

- Produce presentation materials that can be distributed among Taskforce members and for Collaborative use when speaking on related topic areas.
- Produce Deliverables (white papers, reports, studies, etc.) based on available funding; if funding is not available, then the Taskforce will produce content to be posted on PCPCC's website.
- Identify and develop Case Studies
- Perform State-Scans

AAMC Report Examines Institutions' Adoption of Medical Home

A new report from the AAMC provides the results of a 2010 member institution survey designed to determine how attributes of the patient-centered medical home are being incorporated into the clinical education environment. While few studies have examined how medical homes have been integrated into teaching settings,

"Moving the Medical Home Forward: Innovations in Primary Care Training and Delivery," offers examples of seven medical schools successfully delivering patient-centered care to their communities. The report also discusses the challenges and opportunities in the post-health care reform era for medical schools and teaching hospitals to

develop new ways to train physicians and improve the health of the public.

https://services.aamc.org/publications/index.cfm?fuseaction=Product.displayForm&prd_id=316&prv_id=392&cfid=1&cftoken=D159136A-C2AC-8F9B-BC0D1C80693BD367

Other Publications of Interest

1. American College of Physicians says Subspecialist “Neighbors” Vital Part of Patient Centered Medical Home

A new policy paper from the American College of Physicians (ACP), entitled The Patient Centered Medical Home Neighbor: The Interface of the Patient Centered Medical Home with Specialty/Subspecialty Practices, defines the concept of the PCMH neighbor and lays out a framework for how improved collaboration can be fostered between the PCMH and its medical neighbors. A PCMH neighbor is defined as a specialty or subspecialty medical practice that:

- Ensures effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care.
- Ensures appropriate and timely consultations and referrals that complement the aims of the PCMH practice.
- Ensures the efficient, appropriate, and effectively flow of necessary patient and care information.
- Effectively guides determination of responsibility in co-management situations.
- Supports patient-cen-

tered care, enhanced care access, and high levels of care quality and safety. And,

- Supports the PCMH practice as the provider of whole person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other health care professionals.

The conclusions of the paper, developed by a workgroup of ACP’s Council of Subspecialty Societies (CSS), are widely supported by subspecialist physicians. For more information and to download a copy of this paper, go to http://www.acponline.org/pressroom/pcmh_neighbors.htm

2. Health IT in the Patient Centered Medical Home

This resource is a compendium of articles, case examples and tools for providers across the health care continuum to engage patients in their own care. Transforming Patient Engagement: Health IT in the Patient Centered Medical Home includes 15 core articles and 23 case examples to help primary care clinicians enhance patient engagement in the process of care delivery. This com-

prehensive resource was compiled by the Patient Engagement Task force of the PCPCC’s Center for eHealth Information Adoption and Exchange, and includes articles for a range of stakeholders—primary care providers, patients, caregivers, health IT developers, policy makers, employers and the broad spectrum of clinical team members who serve patients every day. The Health IT in the PCMH is available at <http://www.pcpcc.net/guide/health-it-pcmh>

3. Clinical Decision Support in the Medical Home

Also produced by the PCPCC’s Center for eHealth Information Adoption, the report Clinical Decision Support in the Medical Home presents the types of clinical decision support available, ways to implement it smoothly into physician practices, and keys to effective use. It also outlines how clinical decision support can help primary care providers demonstrate they have met the federal government’s “meaningful use” criteria, which is required for them to tap into ARRA funding. Clinical Decision Support in the Medical Home is available at <http://www.pcpcc.net/guide/clinical-decision-support>

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

4. Health Affairs Article - How Geisinger's Advanced Medical Home Model Argues the Case for Rapid-Cycle Innovation

Payment and delivery system initiatives proposed in the Patient Protection and Affordable Care Act of 2010 need to be tested, scaled, and adapted with an urgency not evident in previous CMS demonstration project. In this publication, Geisinger Health Plan discusses lessons they have learned through care redesign, specifically from their advanced medical home model, ProvenHealth NavigatorSM. Geisinger has been continuously modifying the model to

improve quality and value. They suggest that the most important component in their medical home model has been embedding nurse case managers into community practices and using real-time feedback from their patients on the use of health services. <http://content.healthaffairs.org/content/29/11/2047.abstract>

5. Issue brief: Bringing transitional care into the mainstream

This Commonwealth Fund issue brief describes two projects that identified the essential elements of effective care management interventions and looked at how to move

one such intervention, the Transitional Care Model, into mainstream practice. TCM incorporates both in-person contact and a nurse-led, interdisciplinary team approach. It can reduce costs and improve patient health status, but fundamental changes are needed for mainstream practice use. Among them: changed structures, care processes, payment models; and health professionals' roles and relationships, to each other and to patients. <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Nov/Scaling-Up-Transitional-Care.aspx>

URAC DEVELOPS PATIENT CENTERED HEALTH CARE HOME (PCHCH) PROGRAM TOOLKIT

URAC (Utilization Review Accreditation Commission), a leading health care accreditation and education organization, announced the release of its Patient Centered Health Care Home Program Toolkit on December 29th. This new program provides an educational, step-wise, self-paced approach to guide health care practices, and sponsoring health plans, insurers, and pilot programs, on how practices can transform themselves into a patient centered health care home: URAC's PCHCH Program Toolkit includes: http://www.urac.org/healthcare/prog_accred_pchchp_toolkit.aspx

- Practice Assessment Standards, Interpretive Guidance and Checklist – Enabling practices to self-assess themselves in the following key areas:
 - Core Quality Care Management
 - Patient-Centered Operations Management
 - Access and Communications
 - Testing and Referrals
 - Care Management and Coordination
 - Advanced Electronic Capabilities
 - Performance Reporting and Improvement
- Performance Measures Information Resource – Identifying measures directly pertinent to the provision of high quality patient centered care.
- Survey Information Resource – Providing an overview and recommendation of publicly available patient experience surveys.