Patient-Centered
Primary Care
COLLABORATIVE

COMMUNITY CONNECTIONS

IN THE MEDICAL NEIGHBORHOOD: THE FUTURE OF THE PRIMARY CARE MEDICAL HOME

PCPCC 2013
ANNUAL FALL CONFERENCE

October 13th - 15th

Hyatt Regency Bethesda

SPEAKER QUESTIONNAIRE ADDENDUM

About this Book

You may notice that none of our presenters from the seven panels will be providing formal slide presentations. Instead, our panels have been designed to promote thoughtful discussion; engage panelists and audience members in a dialogue, and promote meaningful exchanges of ideas, lessons learned, and best practices.

As a means to provide more information, we're providing all participants with this handy "Addendum." Prior to their presentations, all panelists (excluding moderators) were asked to fill out a questionnaire that provided more detailed about their organizations, and additional information related to their activities around patient engagement, quality improvement, and working with partners in the medical neighborhood.

Here are the questions we asked:

- Describe the core members of the PCMH care team in your organization (physician, nurse practitioner, care coordinator, health coach, social worker, etc.).
- How do you delineate the respective roles of the medical home and its "neighbors"? (i.e. care coordination agreements, care plans, referral and follow-up guidelines, etc.).
- How is information shared between the medical home team, the patient/caregivers, and other providers of care? (i.e. shared EMR, patient portals, personal health records, etc.).
- How are patients supported to become active as equal members of the care team to the degree they choose to be involved (i.e. patient activation assessments, peer support, health coaching, mobile technologies, etc.).
- Describe a non-clinical community partnership that has been especially successful (YMCA's, faith community, workplace wellness programs, etc.).

Their answers are provided here, and organized by Panel. Please note that some panelists chose not to submit responses, and have been left blank.

All speaker biographies (including moderators, workshop panelists, etc.) are included in the main conference program.

MONDAY, OCTOBER 14th

Monday, October 14th I 2:15 pm – 3:00 pm
Panel 1
Won't You Be My Neighbor?
Accountable Care Collaborations in the Medical Neighborhood

This panel will focus on "what it takes" to be a successful medical neighborhood and include multiple perspectives – payment, policy, patient and provider – to identify the necessary collaborations, processes, and systems that will drive success in the complicated yet rewarding accountable care ecosystem.

Speakers:

- Blair Childs, Senior Vice President, Public Affairs, Premier Healthcare Alliance **Moderator*
- Michael P. Jeremiah, MD, FAAFP, Chair, Department of Family and Community Medicine, Carilion Clinic
- Shari Medford, MD, FAAP, Physician, Amarillo Children's Clinic
- Xavier Sevilla MD, MBA, FAAP, Vice President, Clinical Quality, Catholic Health Initiatives
- Brad Thompson, MA, LPC, Director and Co-Founder, HALI Project

Michael P. Jeremiah, MD, FAAFP
Carilion Family Medicine
1 Riverside Circle, Suite 102 I Roanoke, Virginia 24016

Describe the core members of the PCMH care team in your organization.. Core members of our team include the PCP/physician, nurse practitioner/physician assistant (some practices), nurse, front office, and a care coordinator. Additional members of the PCMH efforts in our system include 3 senior care coordinators (divided by regions) and 1 behavioral health care coordinator, social worker (one site), pharmacy (one site).

How do you delineate the respective roles of the medical home and its "neighbors"?. We have a PMCH steering committee that has helped to seek feedback on our model, expand the model to additional sites, and optimize processes and structure in existing sites. This committee has helped to shape many of the workflows and transition of care elements and to design a dashboard of metrics (disease/prevention/utilization). We have separate care integration and ambulatory quality committees that have brought together members of different departments to work on common initiatives (our current one is COPD). A system committee (Transformation Oversight) oversees and coordinates the efforts of the other committees.

How is information shared between the medical home team, the patient/caregivers, and other providers of care?. Common EMR system (EPIC) among all primary care and specialty providers in the Carilion Clinic system; non-Carilion providers are offered view-only access to the EMR. We use a patient portal (MyChart) to share lab results and allow for patients to request appointments, refills, and ask questions. The EMR allows for messages to staff and provider to provider to coordinate efforts, make referrals, and ask questions.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved (i.e. patient activation assessments, peer support, health coaching, mobile technologies, etc.). This is still evolving in our system. We had a patient advisory council during our first 2 years, which was helpful in our initial efforts. Was difficult to sustain interest/involvement. We are considering another attempt. We are implementing an ambulatory CG-CAHPS patient satisfaction survey process. The MyChart patient portal allows for health coaching between visits.

Describe your involvement in a non-clinical community partnership that has been especially successful. . We have helped to lead a community (Roanoke Valley) assessment in collaboration with other "safety net" providers including the other major healthcare delivery system, a free clinic, an FQHC, the United Way and others. Collaborative recommendations were made and we are in the process of following up with some further assessments and pilot efforts to improve coordination of care and resources.

Shari Medford, MD, FAAP

Amarillo Children's Clinic I #17 Care Circle I Amarillo, TX 79124

Describe the core members of the PCMH care team in your organization. The staff at Amarillo Children's Clinic consists of three board certified pediatricians: Rex Fletcher, M.D., Rebecca Scott, M.D. and Shari Medford, M.D. as well as three registered pediatric nurse practitioners: Jane Meyers, Janice Ray and Christy Blake. Two registered nurses are available for care coordination. Brad Thompson with the Hali Project acts as a patient partner and attends clinic weekly to empower patients and their families to be active participants in their medical care.

How do you delineate the respective roles of the medical home and its "neighbors"? The pediatrician assumes the lead role in organizing the care of the patient. Nurse practitioners are available to each pediatrician to see patients on an alternating schedule for well visits and for occasional acute care visits. The registered nurses are available at the pediatricians' request to help with referrals and care coordination, as well as follow-up of each patient. Many of these processes have become streamlined with the use of the electronic medical record.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? The majority of patient information is shared between medical care providers and the medical home team through the electronic medical record. Patient referrals and care coordination can be tracked through the EMR. Currently information is shared with patients and caregivers by direct communication with office staff: RN, PNP, or MD.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Patients and their parents are encouraged during clinic visits by the patient partner to participate as active members in their medical care. The families are invited to empowerment training, which is regularly offered for them. The purpose of the training is to give them the skills and encouragement to participate as equals in their medical care.

Describe your involvement in a non-clinical community partnership that has been especially successful. The Hali Project is a non-profit organization that provides counseling and education services for communities who seek to be more inclusive of individuals with special needs. That work includes working with families, the education system and the medical system. Brad Thompson is currently the director and has been coming to Amarillo Children's Clinic on a weekly basis for approximately 10 years. This partnership helps patients and their families having problems in just about any arena of life including education, transportation, family and marital counseling, financial and peer support.

Xavier Sevilla MD, MBA, FAAP

Catholic Health Initiatives I 198 Inverness Drive West I Englewood, CO 80112

Catholic Health Initiatives is a national nonprofit health system with headquarters in Englewood, Colo. The faith-based system operates in 18 states and includes 86 hospitals; 40 long-term care, assisted- and residential-living facilities; two community health-services organizations; two accredited nursing colleges; and home health agencies. The CHI physician enterprise has approximately 3500 employed clinicians both primary care and specialty practice. The mission of CHI is to create healthier communities in the geographic areas where we are present.

Describe the core members of the PCMH care team in your organization. *Presently it contains clinicians, population heath coach, care coordinator, and a pharmacist in two of our markets*

How do you delineate the respective roles of the medical home and its "neighbors"? Co-management agreements

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Shared EMR

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How are patients supported to become active as equal members of the care team to the degree they choose to be involved? We are in the process of creating Patient Advisory Boards in each of our primary care practices

Describe your involvement in a non-clinical community partnership that has been especially successful.
Reading Youth violence coalition with local Youth clubs and organizations in Reading PA; **Health Hub** in Lincoln, Nebraska with 40 community service agencies.

Brad Thompson, MA, LPC

The HALI Project I c/o Brad Thompson I 26551 Newton I Canyon, TX 79015

The mission of The HALI Project is to serve individuals with special needs and chronic illness and their families and the people who serve them so that they may contribute to their communities in a meaningful way.

How do you delineate the respective roles of the medical home and its "neighbors"?
From the support side, we work to provide information, emotional support, and access to community resources to try to make it easier for the individual to adhere the plan of care.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved?
They are encouraged during visits by the patient partner, and are invited to empowerment training, which is regularly offered for them. The purpose of the training is to give them the skills and encouragement necessary to participate as equals – because of their unique perspective – in every conversation concerning their situation.

Describe a non-clinical community partnership that has been especially successful. The Hali Project's partnership with Dr. Medford has opened doors to serving families in every arena imaginable – schools, churches, transportation, marriage, and peer support.

Monday, October 14th I 3:30 pm – 4:15 pm
Panel 2
Transforming the Patient Experience in the Medical Home and Beyond

This panel will focus on how the patient experience will and should change in the medical neighborhood, as providers adopt and enhance care teams, care coordination, health IT and patient-provider communications.

Speakers:

- Edwin Fisher, PhD, Global Director, Peers for Progress
- David Kendrick, MD, MPH, Chief Executive Officer, MyHealth Access Network
- Katherine Nordal, PhD, Executive Director, American Psychological Association
- Francis Rienzo, MBA, Senior Director, Partners in Patient Health, Sanofi **Moderator*

David Kendrick, MD, MPH

MyHealth Access Network I 16 E 16th St., Suite 405 I Tulsa, OK 74119

MyHealth Access Network is a non-profit coalition of more than 150 health care organizations in northeastern Oklahoma, with a goal to improve health care quality and the health of area residents while controlling costs. MyHealth Access Network is one of a select few national sites receiving a three year federal Beacon Community Award from the Office of the National Coordinator for Health Information Technology. We seek to encourage greater communication and coordination among care providers through expanded use of health information technology and health information exchange. Partners include: hospitals; first responders; employers; public leaders; health insurance companies; university medical systems, tribal health systems; safety-net or essential care clinics; physician practices; laboratories; public health organizations; pharmacies; patients and specialists.

Describe the core members of the PCMH care team in your organization.: Physician, nurse practitioner, care coordinator, health coach, social worker, etc. are included in our PCMH and Neighborhood model of care.

How do you delineate the respective roles of the medical home and its "neighbors"? MyHealth hosts an electronic referral management system, which connects 2000 endpoints from multiple health systems into a common referral network. We measure, monitor, and report on performance related to care transitions.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Shared EMR with internal providers, HIE moves clinical data between organizations, Patient portal for patient engagement, Online eConsults for provider driven care coordination.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved (i.e. patient activation assessments, peer support, health coaching, mobile technologies, etc.): Providing tools for shared decision-making and patient education, including mobile phone apps.

Describe a non-clinical community partnership that has been especially successful. Coordination of Faith community and health departments to roll out a patient focused smartphone app. Coordination with employers to deploy continual health risk assessment tools and patient engagement with patient portal and communication tools.

Monday, October 14th I 3:30 pm – 4:15 pm
Panel 3
Building Healthy Communities:
Partnerships to Reduce Disparities and Improve Population Health

This panel will emphasize the role of safety net providers, public health and both formal and informal services for patients and families in the community working in partnership to connect high-risk patients to quality primary care, behavioral health, social services, and community supports.

Speakers:

- Melinda K. Abrams, MS, Vice President, Patient-Centered Coordinated Care Program, The Commonwealth Fund **Moderator*
- Craig Brammer, Chief Executive Officer, Greater Cincinnati Health Council
- Sara Gillen, MPH, Vice President of Health Services, Harlem United Community AIDS Center, Inc.
- Matthew Longjohn, MD, MPH, Senior Director, Chronic Disease Prevention, YMCA
- Suzanne Schrandt, JD, Deputy Director, Patient Engagement, Patient-Centered Outcomes Research Institute

Craig Brammer

HealthBridge is a regional healthcare improvement organization (the Health Collaborative) and a hospital and long-term care member organization (the Health Council). Under new, singular leadership team these organizations have an aligned mission of making health and healthcare a competitive advantage for Greater Cincinnati. In addition we offer solutions to other communities in the country with similar aims.

Describe the core members of the PCMH care team in your organization. Our organization does not deliver or finance care. Rather we help those who do by catalyzing their collective will, ideas and execution to drive large-scale improvement initiatives. Our staff of physicians, technology experts, improvement consultants and others work on a daily basis with employers, health plans, civic leaders, health systems and other providers to help align the PCMH regional agenda. As a result, Greater Cincinnati has more Level-3 PCMH practices than most any community in the US. This same team is currently leading one of the 7 CMS Comprehensive Primary Care Initiative demonstrations and is working closely with the State of Ohio to accelerate PCMH beyond our region.

How do you delineate the respective roles of the medical home and its "neighbors"? One exciting aspect born from the CPCi learning community has been the "coordination of the care coordinators" in our region. While each segment of the medical neighborhood has capacity in this role, we have begun to align regional expectations in having the primary care coordinator serve as the quarterback for all coordination services. We think this is an important first step in providing a more patient-centric and seamless experience of care for our patients, and closely tracks with the tenets of the PCMH. And while this is very much a work in progress, it shows much promise.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Information sharing happens in a multiplicity of ways but one unique regional solution hosted by HealthBridge involves instant electronic notification to the primary care practice when one of their patients is seen by an area hospital, either in the emergency department or through an admission. Importantly, this requires competing health systems to agree to notify one another about their respective patients. Instant notifications are also sent to area ageing organizations and other "non-medical" organizations.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Exploring Patient & Family Advisory Councils can be a highly satisfying way for Providers and care teams to connect with their patients outside of the exam room, and we have heard great anecdotal evidence of this. We also encourage our practices to communicate the transformative changes they are making to their patients. This can help facilitate the sometimes onerous conversation "what does it mean to be a PCMH?", as evidenced by things such as open access policies and how new care-team members will be approaching patient care more holistically.

Describe your involvement in a non-clinical community partnership that has been especially successful. Greater Cincinnati has a large Council on Aging organization ($100 million annual budget) and a local tax levy, all targeted to actively help seniors remain in the most appropriate and efficient care setting, while maintaining the highest possible standard of living. A strong partnership with health systems, PCMHs and the aging organizations has resulted in some of the lowest 30-day readmission rates in the country according to CMS and the Lewin Group. Care navigation, performance measurement and electronic hospitalization notifications are increasingly part of this emergent medical neighborhood.

Sara Gillen, MPH

Harlem United I 179 E. 116th Street, 2nd floor I New York, NY 10029

Harlem United is a multi-service organization established in 1988 to address the epidemics of HIV, homelessness and mental illness among marginalized groups in Upper Manhattan, including drug users, men of color who have sex with men and women at high risk for HIV. Our goal is to provide 100% access to quality healthcare and support services to achieve zero disparities in health outcomes. Harlem United eliminates health disparities through a holistic and innovative continuum of high quality services, ensuring they are easily accessible and accepting of each person's life experiences, ensuring dignity and integrity for each consumer as we foster their development in a healthy and healing community. We provide emergency, transitional and permanent supportive housing; community health screening, education and training programs; community organizing and advocacy; and comprehensive primary healthcare including medical services, oral healthcare and behavioral health programs. Our core values include dignity for all, integrity in everything we do, acceptance of each person's unique life circumstances and experiences, a commitment to quality and innovation in service delivery to ensure we are meeting our goals and accomplishing our mission.

Describe the core members of the PCMH care team in your organization. Our clinics are small in space and patient volume, but our clients are complex with chronic conditions that include mental illness, substance abuse, homelessness, HIV, hepatitis, and metabolic disorders. The core team consists of a medical provider (MD, NP, or PA), nurse leader, medical assistant and patient navigator. Additional support team members are added as needed: psychiatric nurse practitioner, psychotherapist, and treatment adherence counselor.

How do you delineate the respective roles of the medical home and its "neighbors"? This is a particular challenge for our organization. It's easier to do with in-house "neighbors" (i.e., our housing and addiction assistance programs). With external providers, we use dedicated referral specialists and nursing staff to assist with communication and information sharing. The referral specialists coordinate specialty visits, track down specialists who have seen our patients for consultation notes and discharge summaries. We have formal linkages with two area hospitals. However, we have had challenges securing information and assistance from hospital based specialty services.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Because we are a small clinic, we have not yet expanded EMR sharing through RHIOs, although it is something we are considering. We share information through a patient portal and distribution of medical summaries at each visit. The EMR allows all staff in the agency to stay abreast of developments in a client's care, since our Housing and treatment adherence staff can access lab documents, support attendance at appointments, and provide support and education to clients in other agency settings.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved?
Coming out of the tradition of HIV services, our culture has always supported active client participation and teaming in the care environment. We have education and support groups for clients to improve their knowledge and motivation for treatment and health-seeking behaviors, and we facilitate peer-training programs so that clients can provide education and support to one another. We also have consumer advisory boards at each clinic for client feedback and suggestions.

Describe a non-clinical community partnership that has been especially successful. Harlem United's community health and healthcare divisions have a long history of working with various community partners to promote healthcare access and HIV/STI prevention in greater Harlem. A few partnerships come to mind:

New Hope for the World Ministries partnership: This small but powerful coalition of local ministries organizes an annual, week-long health fair on the main thoroughfare in Harlem. Each year the ministry tackles an important health issue in the community (2011 was HIV, 2012 was domestic violence). Harlem United is a key partner in the health fair. Our Chief Medical Officer delivers health education from their pulpits, and our staff conduct health assessments and screening for HIV, STIs and Hepatitis C. We then expedite medical and dental appointments for community members who have no healthcare.

New York City Department of Health and Mental Hygiene: Harlem United and the NYC DOH are long-standing partners in the public health arena. We have collaborated over the last two years to implement and evaluate a medical record template designed to promote HIV prevention behaviors among HIV positive patients. The data will inform a template that will be expanded to other community health centers and Ryan White clinics in New York City.

Shelter/Drug Treatment/Supportive Housing providers: We have linkages set up for same day access to medical, dental and psychiatry services.

Higher education: We have relationships with New York University, Columbia University, Touro College Pharmacy program, Lutheran Medical Center Advanced Education in General Dentistry, and City University's Sophie Davis School through which we place students in our practice. The students range from medical technicians and pharmacy students, graduate level social work and medical students, to post graduate fellowships in community based dentistry. Through these partnerships, we help to develop the next generation of providers in community based practice.

Matthew Longjohn, MD, MPH
YMCA of the USA I 101 N. Wacker, Chicago, IL, 60606

YMCA of the USA (Y-USA) is the national resource office for the more 2,700 Ys with Y associations and branch locations at 10,000 community sites across the nation. Collectively referred to as "the Y," it is the oldest and largest non-profit community-based organization in the country. The Y employs 250,000 staff and 550,000 volunteers to engage 9 million youth and 12 million adults across the country each year. Since the formation of the first Y association over 160 years ago, the Y has worked to address health disparities and build a healthy spirit, mind, and body for all. Over the past decade, Y-USA has transformed the Y organization and made innovative changes to build capacity of local Ys to meet the country's most pressing health demands. Efforts such as Healthier Communities Initiatives (HCI) to create policy, systems, and environment changes, and chronic disease prevention programs such as the YMCA's Diabetes Prevention Program and the LIVE**STRONG**® at the YMCA program for cancer survivors demonstrate that Ys are impactful organizations operating within the public health system. Through public health services and initiatives like these, Y staff members are serving as an effective public health workforce of lay health leaders extending the public health system's reach in local communities.

Describe the core members of the PCMH care team in your organization. In the past 3 years, Y-USA has trained more than 1500 "Lifestyle Coaches", who are lay health workers with demonstrated skills in motivational interviewing techniques, group facilitation, and behavior change methods. These are our front-line staff in secondary and tertiary prevention programs such as the YMCA's DPP and LIVE**STRONG** at the YMCA. Program Coordinators, Healthy Communities "Coaches" and other senior leaders of local Ys have also been trained to generate partnerships with health care providers and systems, to establish formal and informal referral systems, and to ensure that Ys are a part of the PCMH models in their communities.

How do you delineate the respective roles of the medical home and its "neighbors"? It varies upon the program or initiative that is being organized. The most commonly used legal tools are Partnership or Collaboration Agreements, Joint Use Agreements, Data Use Agreements, and Business Associates Agreements.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? It varies upon the program or initiative that is being organized, and the infrastructure and data systems of local YMCAs and their partners. One novel solution for information sharing is the Mynetico platform, which allows Y-USA to roll-up

program data from the individual, group, coach, community, state, or program levels in real-time to monitor outcomes such as attendance, weight loss, self-reported behaviors, etc.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved?
Health coaching is at the center of most of our efforts, whether this is on the fitness floor as part of a worksite wellness program, or in innovative secondary or tertiary prevention programs such as those mentioned above.

Describe your involvement in a non-clinical community partnership that has been especially successful. Our goal is to bring the neighborhood to the table in conversations with health care providers and partner systems. We have thousands of local partners that participate in coalitions organized or supported by local YMCAs, and many are looking to the Y to open doors and make connections to health care partners.

Suzanne Schrandt, JD

Patient-Centered Outcomes Research Institute

The **Patient-Centered Outcomes Research Institute (PCORI)** helps people make informed health care decisions, and improves health care delivery and outcomes, by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader health care community. Created by the Affordable Care Act, PCORI is an independent non-profit funder of patient-centered research. It is the vision of PCORI that patients and the public have the information they need to make decisions that reflect their desired health outcomes

Describe the core members of the PCMH care team in your organization. PCORI funds research across five national priority areas including one focused on “Improving Healthcare Systems”. This funding area seeks applications for comparative effectiveness research (CER) designed to provide information that would inform critical decisions that face healthcare system leaders, policy makers, clinicians, and the patients and caregivers who rely on them. However, PCORI has funded CER exploring varying models of care delivery across our other priority areas as well. Funded research includes projects evaluating medical home models in chronic disease and mental health, as well as within major health systems.

How do you delineate the respective roles of the medical home and its “neighbors”? Our research portfolio includes projects with varying models and definitions. While our review criteria delineate specific parameters such as robust patient and stakeholder engagement and appropriate inclusion of vulnerable populations, we seek research proposals that are creative and innovative.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? While PCORI is not engaged in the direct provision or coordination of care, our standards for the research we fund include strict requirements for patient and stakeholder engagement. The review criteria by which applications are evaluated include the need for the research question to be “patient-centered” and for the research to include patients and stakeholders from question formation all the way through to the dissemination of findings.

Describe your involvement in a non-clinical community partnership that has been especially successful. While PCORI is not engaged in the direct provision or coordination of care, many of our funded projects explore the combination of clinical with non-clinical partners such as community groups and advocacy organizations.

Monday, October 14th I 5:00 pm – 5:45 pm
Panel 4
Strengthening the Medical Home Workforce: The Future of Primary Care Education & Training

This panel will build on the work of the Education & Training Task Force to discuss how residency and training programs, and graduate medical education can adopt elements of the medical home and medical neighborhood model.

Speakers:

- Marietta Angelotti, MD, Associate Medical Director, Office of Quality and Patient Safety, New York State Department of Health
- Ted Epperly, MD, FAAFP, President & Chief Executive Officer, Family Medicine Residency of Idaho **Moderator*
- Mollie Scott, BCACP, CPP, PharmD, Regional Associate Dean and Clinical Associate Professor, UNC Eshelman School of Pharmacy, Asheville Campus
- Bill Warning, MD, Program Director, Crozer-Keystone Family Medicine Residency Program
- Ted Wymsylo, MD, Director, Ohio Department of Health

Marietta Angelotti, MD

Office of Quality and Patient Safety I New York State Department of Health
Corning Tower, Empire State Plaza I Albany, New York

About the New York State Department of Health: We protect, improve and promote the health, productivity and well being of all New Yorkers. **Vision:** New Yorkers will be the healthiest people in the world - living in communities that promote health, protected from health threats, and having access to quality, evidence-based, cost-effective health services. **Values:** Dedication to the public good, Innovation, Excellence, Integrity, Teamwork, Efficiency.

Office of Quality and Patient Safety: The goals of the Office of Quality and Patient Safety include executing the Triple Aim—improved care and better health for the population at lowered costs—and positioning DOH as a national leader in quality and patient safety, as well as data management and use. By developing a multi-year quality and safety agenda for New York, OQPS hopes to collaborate with various stakeholders, including providers, researchers, and others on projects that will improve the quality of care for patients and provide a standardized approach for all quality and patient safety reporting to better inform and target opportunities for improvement.

Hospital Medical Home Demonstration Program: This $250 million program, funded by CMS through an 1115 waiver, is intended to transform the primary care received by Medicaid members in outpatient training clinics of primary care residency programs, and train new physicians in the principles of patient centered medical homes. There are approximately 5,000 participating primary care residents at 62 training hospitals, 119 residencies, and 162 outpatient clinics across New York State.

Describe the core members of the PCMH care team in your organization. Each of the residency clinics has a unique structure but typically the team includes representatives from the hospital, residency program attendings and residents, clinic management, case managers and case coordinators, and allied health personnel.

How do you delineate the respective roles of the medical home and its "neighbors"? These roles are uniquely determined by each of the individual residency programs and their associated participating primary care continuity training sites. The Hospital Medical Home Demonstration Program does require programs to develop a high degree of coordination between the sponsoring hospital, the residency program and the outpatient practice, as well as between

specialists and primary care. Each program selected one of 4 Care Coordination Projects to complete including Care Transitions, Integration of Behavioral Health, Cultural Competence, or Increased Access to and Coordination of Specialty Care. They were required to develop a work plan to improve metrics in this area and will report on progress each quarter.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Programs using funds from this program for EHRs are expected to purchase and implement EHRs that are connected to and use information from the Regional Health Information Organizations , be interoperable between clinic and hospital, and meet the requirements of Level 2 or 3 PCMH by NCQA 2011 standards.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? This is unique to each individual practice. There are requirements involving discharge summaries, medication reconciliation, use of interpreters, and patient and family information sharing that serve to bring patients to the center of the care delivery process.

Describe your involvement in a non-clinical community partnership that has been especially successful. This program has been strongly supported by the hospital associations and the Primary Care Development program in every aspect from PCMH consulting to information dissemination and assistance with reporting requirements.

Mollie Scott, BCACP, CPP, PharmD

UNC Eshelman School of Pharmacy I One University Heights, CB 2125 I Asheville, NC 28804

Mountain Area Health Education Center (MAHEC) was established in 1974 to provide high quality health care in Western North Carolina, train physicians and other health care professionals, and to develop innovative healthcare models. The organization focuses on training physician residents in family medicine and obstetrics/gynecology, pharmacy residents in ambulatory care, dental residents, and geriatricians to serve as the foundation of primary care in the region. The Family Health Center is recognized as a patient-centered medical home, and provides quality healthcare for a wide variety of patients including families, women and children, older adults, and the medically underserved. Innovative models of care include providing team-based care with embedded team members including clinical pharmacist practitioners and behavioral medicine specialists. In addition, MAHEC reaches out to practices throughout the region that need assistance with advancing their medical practices in this changing healthcare environment.

Describe the core members of the PCMH care team in your organization. MAHEC has multiple team members that contribute to the success of our model, improve quality of care, and lower costs. Team members include physicians, physician assistants, nurse practitioners, care coordinators from Community Care of North Carolina, pharmacists, behavioral medicine specialists, nurses, dieticians, and others. In addition, students in medicine and pharmacy train together and participate in didactics, patient care, and service learning activities side-by-side.

How do you delineate the respective roles of the medical home and its "neighbors"? MAHEC works closely with Community Care of North Carolina to ensure the provision of quality care that is cost effective for high-risk patients including those with Medicaid and dual-eligibles. An interprofessional "transitions in care" model assists those patients who transitioning from our inpatient family medicine service to home, resulting in decreased 30-day re-admissions. Currently, a regional Bone Health Advisory Team with representatives from primary care, specialty care, and hospitals in the region is meeting to establish a fracture liaison service and to improve quality of care for our population with low bone mass and osteoporosis.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? MAHEC has an EMR that can be accessed at the local hospital during transitions in care. This includes patient care notes as well as a messaging system that all team members can access.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Clinical pharmacist practitioners teach patient self-management techniques with emphasis on anticoagulation and diabetes. Many patients participate in educational classes taught at Mission Hospital's Health Education Center that focus on improving understanding of chronic illness. Specific initiatives at the Family Health Center that focus on engaging patients includes pregnancy centering classes, osteoporosis clinic, pain management clinic, diabetes services, and anticoagulation clinic. A recent project led by an undergraduate intern focused on improving health literacy for patients who are anticoagulated.

Describe your involvement in a non-clinical community partnership that has been especially successful. MAHEC initiated a workplace wellness program several years ago that is based upon the model of the award-winning Asheville Project. Employees are paired with a clinical pharmacist practitioner who serves both as a health coach and as a medication management expert. The clinical pharmacist practitioner sees the patient monthly and discusses lifestyle changes that can improve chronic conditions, and partners with the patient's physician to adjust and monitor medication therapy to achieve desired therapeutic goals.

Medical, pharmacy, and nursing students participate in a monthly team night at Asheville Buncombe Community Christian Ministry Clinic together. This clinic serves as a safety net clinic for the Asheville area, and is staffed with full-time staff members as well as volunteers. Five student teams made up of a medical student, pharmacy student, and nursing student, work together to see patients in clinic. Students have defined roles and responsibilities as outlined in the core competencies for interprofessional education, formulate a treatment plan, and discuss the plan with faculty physicians, pharmacists, behavioral medicine specialists, and an ethicist. Students reflect on the experiences at social gatherings and at an end-of-the-year event that celebrates their contribution to those in need within our community.

MAHEC works closely with UNC Asheville to host a summer internship for undergraduate students interested in medicine, pharmacy, and dentistry. Students apply for selection into the 8-week program, and participate in patient care shadowing experiences along with interprofessional enrichment programs to introduce them to topics in health care including rural health, health careers, the patient-provider relationship, professionalism and work life balance, and others.

Bill Warning, MD

Crozer-Keystone Family Medicine Residency Program I 1260 E. Woodland Ave., Suite 200 I Springfield, PA 19064-3988

The **Crozer-Keystone Health System** is a Non-profit, integrated Health System consisting of 5 hospitals and a large primary care physician network. Crozer has Residency Training Programs in all the primary care specialties including Family Medicine, Internal Medicine, Pediatrics and Obstetrics. Our primary care physician network, of 35 offices, was the first large network in the Northeast to achieve Level 3 NCQA PCMH recognition. Crozer is a clinical campus for Temple University Medical School and sponsors Allied Health schools in many disciplines.

Describe the core members of the PCMH care team in your organization. RN Nurse Case Manager, Clinical Pharmacist, MSW, Behavioral Health professionals, Attending and Resident Family Physicians

How do you delineate the respective roles of the medical home and its "neighbors"? Crozer-Keystone Health System designed a "Physician Partner" entity made up of the Primary Care Physicians in our Crozer-Keystone Health Network and the Specialty physicians in our System. This entity outlines the care coordination and care plan follow up expected for the PCPs and the Specialists.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Crozer-Keystone Health System shares a common EMR with all the providers in the Health Network and a Community EMR with the providers in the Health System. Crozer has a fully functional Patient Portal for confidential exchange of information with patients.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved Patients are engaged in completion of a Self-Management Assessment form as part of their PCMH Care Plan. This form is reviewed and updated regularly by all members of the care team. Patient outreach and communication occurs mainly through the Patient Portal. Several practices offer Group visits and Home Visits as another form of Patient engagement.

Describe your involvement in a non-clinical community partnership that has been especially successful. Crozer-Keystone Health System includes a state-of-art Healthplex Wellness facility designed to promote and maintain wellness and health in our community. The Healthplex runs many diverse classes, summer camps and educational sessions to address common health problems and disparities in our community.

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Ted Wymsylo, MD

Ohio Department of Health I 246 N. High St. I Columbus, OH 43215

The mission of the **Ohio Department of Health** is to "Protect and improve the health of all Ohioans by preventing disease, promoting good health and assuring access to quality care." The Ohio Department of Health's public health vision is "Optimal health for all Ohioans."

Describe the core members of the PCMH care team in your organization. Our core team at the Ohio Department of Health is comprised of myself, Heather Reed (Chief, Bureau of Community Health Centers and Patient Centered Primary Care), and Amy Bashforth (Manager, Ohio Patient-Centered Primary Care Collaborative). We have a number of collaborating partners who assist us in our statewide efforts to expand the PCMH model, including multiple professional organizations, healthcare systems, employer groups, and patient advocates.

How do you delineate the respective roles of the medical home and its "neighbors"? We are involved in designing the State Innovation Model for Ohio, and determining with multiple stakeholders how care coordination, referrals, follow-up, etc. are expected to roll-out statewide. This work will be completed at about the time of this conference, and I will have the current design at that time.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Within a single system, a shared EMR is allowing co-management of patients by multiple providers. Patient portals are being initiated in the large systems throughout the state. The Ohio Health Information Partnership and HealthBridge have developed an interface to allow them to share information in a network that now blankets the entire state as we move to a statewide Health Information Exchange. Public health is partnering this endeavor so that clinical medicine and public health partners have access to the broad data about total population health in Ohio.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Patient advocates are a part of the leadership of our State Innovation Model design process, are active members of our Ohio Patient-Centered Primary Care Collaborative (OPCPCC), and lead the Patient Advisory Learning Center in OPCPCC. Patient engagement is an important component of our Ohio Patient Centered Medical Home Education Pilot Project (49 practices).

Describe your involvement in a non-clinical community partnership that has been especially successful.

- Local health departments in Ohio have helped develop regional PCMH collaboratives in Cincinnati(Health Collaborative), Cleveland (Better Health Greater Cleveland), Columbus (AccessHealth Columbus), and other communities.
- Healthy Ohio Business Council – A collaborative of businesses in Ohio that meets regularly to advance workplace wellness programs throughout Ohio, led by the Ohio Department of Health.
- Ohio Tobacco Collaborative – ODH-led coalition of businesses and insurers in Ohio who use a single Tobacco Quit line service, receiving a lower rate due to volume purchase contract with vendor.
- Second Chance Trust Fund (ODH) – Donate Life Ohio collaboration to help increase organ donation in Ohio, now engaging hospitals in the effort to enroll new donors. Over 50% of adult Ohioans are now registered as organ and tissue donors through the Bureau of Motor Vehicles.
- ODH-Board of Regents collaboration to get higher education campuses in Ohio to be Tobacco-free…Joint news conference and challenge to all Ohio-funded public schools of higher education to go tobacco-free has resulted in multiple school campuses, including the Ohio State University, going tobacco-free.

TUESDAY, OCTOBER 15th

Tuesday, October 15th I 9:00 am – 9:45 am
Panel 5
Countdown to 2014:
State Perspectives on Health Reform

With states increasingly responsible for carrying out major provisions of the Affordable Care Act, including health insurance marketplaces, Medicaid expansion, ACOs, and enrollment policies, the group will highlight how states are "putting all the pieces together" and collaborating with key players such as patients, policymakers, payers, and health care providers.

Speakers:

- Andy Allison, PhD, Director, Division of Medical Services, Arkansas Department of Human Services
- John Jenrette, MD, Chief Executive Officer, Sharp Community Medical Group
- Craig Jones, MD, Director, Vermont Blueprint for Health
- Jay Lee, MD, MPH, FAAFP, Associate Medical Director, Practice Transformation, MemorialCare Medical Group
- Greg Pawlson, MD, MPH, FACP, Senior Medical Analyst, Stevens & Lee **Moderator*

Andy Allison, PhD

Department of Human Services I Division of Medical Services I Little Rock, Arkansas

The Arkansas Department of Human Services mission is to improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence and promoting better health.

Describe the core members of the PCMH care team in your organization. We envision all primary care practices to reflect upon their current capacity to serve as a primary care medical home. Larger more mature practice sites have restructured clinical teams to allow greater participation by nurses and paraprofessionals in the management of acute and chronic needs of patients. Smaller practices will reflect upon how they can access greater resources for supportive consultation to professionals such as dietitians and social workers on an as needed basis. We believe that every clinical environment will perceive its own opportunities and needs and be innovative in fashioning environments that resulted in greater patient centered, accessible care that manages total cost of care by creating better outcomes over time.

How do you delineate the respective roles of the medical home and its "neighbors"? Effective medical homes must engage patients, manage internal decision-making, and coordinate with external parties in the care of their patient panels. We will explicitly request medical homes to assess their medical neighborhoods for barriers and opportunities to provide patient centered care. Extra per member per month payments for care coordinators and transformation coaches will assist primary care medical homes in navigating difficult environments and prioritizing issues to resolve in their medical neighborhoods. Over time we expect to give the medical homes granular data describing cost of care of their patients outside of their clinical practice and the relative efficiency of their regional consultants and hospitals. Greater reliance upon electronic medical records and health information exchange are essential to increase the flow of information to improve care coordination. We have developed process measures to sustain per member per month payments that include items such as percentage of patients seen by a health professional within 10 days of hospital discharge. Thus we are developing metrics beyond cost of care and traditional quality measures that promote greater structure of elements to facilitate information flow and handoffs in their medical neighborhoods.

How is information shared between the medical home team, the patient/caregivers, and other providers of care?

We are developing patient portals to share quarterly report cards regarding total cost of care, patient panels, quality metrics, and other important attributes expected of our medical home program. All medical homes are expected to have an electronic medical record by year two of the initiative. We expect all medical homes to enroll in our statewide health information exchange to receive hospital discharge information and to facilitate communication across clinical sites.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? We are promoting patient centered care and have dedicated resources to assist practices in transforming to a more medical home environment. We are stressing innovation that it would be appropriate for local communities to include patient advisory boards and patient feedback about practice availability and support of patient needs.

Describe a non-clinical community partnership that has been especially successful (YMCA's, faith community, workplace wellness programs, etc.) We are working in different parts of the state to promote community partnerships to assist our medical home initiative. For example County health departments are quite interested in developing community health workers to support greater population health in concert with medical homes. This public health medical home collaboration could result in substantial impact on medical condition such as hypertension, asthma, and diabetes. It is clear that management of these chronic conditions requires attention beyond the intermittent 10 min. office visit. The financial incentives we have put in place that rewards greater long-term management of these morbidities will motivate local providers to create new relationships that effectively deliver reinforcing messages to patients that can result in greater detection and treatment adherence to the betterment of community health and long-term health system costs.

John Jenrette, MD

Sharp Community Medical Group I 8695 Spectrum Center Boulevard I San Diego, CA 92123

Sharp Community Medical Group, Inc. (SCMG) is a private practice based medical group that was formed in 1989. The group consists of 700 physicians, 200 primary care and 500 specialists, in private practices serving 36 communities within San Diego and Southern Riverside Counties.

Describe the core members of the PCMH care team in your organization. At SCMG the core team consists of the physician, nurse practitioners and physician assistants, the medical assistants, pharmacists, case managers and health coaches. This team is supported at the organizational level through a centralized health coach team, IT support, care coordination activities, hospitalists, SNF physicians and case managers.

How do you delineate the respective roles of the medical home and its "neighbors"? The roles and functions of the care team are standardized and outlined by the central organization and dispersed to the various practices through on site health coaches and medical directors who support each practice. The practices have signed agreements with SCMG to set expectations and use of guidelines and other tools.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Medical homes are on a shared EHR (AllScripts Enterprise) that connects PCPs to SCPs, case managers and patients through the patient portal. The EHR has care gap capabilities that are utilized by the medical home team to manage populations, preventive and chronic care follow-ups.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Patients are engaged through the patient portal and through case management strategies. Early work is underway to utilize social media as a peer support service.

Describe a non-clinical community partnership that has been especially successful. Through our own Sharp Health Plan, patients can engage with "Best Health" to receive tools and feedback on how to improve their own health and wellness.

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Craig Jones, MD

Department of Vermont Health Access I 312 Hurricane Lane Suite 201 I Williston, VT 05495

The **Blueprint for Health** is part of Vermont's overall state led healthcare reform initiatives. The Blueprint program is guiding a statewide transformation process designed to result in more holistic, high quality, preventive health services for all citizens. Key components of the model include Patient Centered Medical Homes (PCMHs) working closely with multi-disciplinary Community Health Teams (CHTs), all-insurer payment reforms, networks of self-management programs in each health service area, and a health information infrastructure to support coordination of services across medical and non-medical services. The Blueprint model is based on local implementation including staffing and operations of the community health teams, and, local program managers and practice facilitators working closely with PCMHs and other stakeholders. The goal is a strong foundation of primary care and preventive health services in each community, which uses comparative evaluation to continuously improve as part of a Learning Health System.

Describe the core members of the PCMH care team in your organization. Teams form within each PCMH including physicians, nurse practitioners, physician assistants, nurses, medical assistants, and other staff. The PCMH team is supported by additional staff from the local community health team such as nurse coordinators, social workers, counselors, dieticians, health educators, coaches, and peer navigators. Additional support is being added by specific insurers such as Medicaid supported teams (nurse coordinator, licensed counselor) to assist with treatment of patients with addiction and mental health disorders in the PCMH setting, and Support and Services at Home Teams (SASH) based at publically subsidized housing to provide in home support to Medicare beneficiaries.

How do you delineate the respective roles of the medical home and its "neighbors"? Part of participation in the Blueprint program includes formation of Integrated Health Services Workgroups in each area of the state. These workgroups include personnel from PCMHs, Community Health Teams, SASH teams, Hospitals, Mental Health & Substance Use providers, public health district offices, and an array of human services providers in each community. These groups meet routinely to plan and improve coordination of more holistic health and human services.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Health information is increasingly shared thru EHRs, a health information exchange network, and a centralized clinical registry – tracking system. This infrastructure is growing steadily and now includes an Integrated Health Record that provides a common view for team members across a community. An intensive effort is focused on end-to-end data quality including data capture in the PCMH setting and transmission into the health information exchange network and central registry.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Each PCMH is scored independently against the 2011 NCQA PCMH standards by a University of Vermont based team. As part of this they are required to demonstrate how they engage patients in self-management support. Community health teams enhance the PCMH capacity to engage patients thru direct access to staff such as counselors, dieticians, educators, coaches, and peer navigators. In each community patients have access to a network of self-management programs including Healthier Living Workshops (chronic disease, pain, and diabetes), Diabetes Prevention Programs, Tobacco Cessation workshops, and, Wellness Recovery & Action Planning programs.

Describe your involvement in a non-clinical community partnership that has been especially successful. The YMCA of Greater Burlington has partnered with the Blueprint to lead a statewide rollout of the CDC's Diabetes Prevention Program. In addition, the YCMA runs a number of wellness programs and provides incentives for people who are referred from PCMHs and CHTs, and who demonstrate a willingness to engage in these programs.

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Jay Lee, MD, MPH, FAAFP

MemorialCare Medical Group I 450 E. Spring Street, Suite #1 I Long Beach, CA 90806

The mission of **MemorialCare Medical Group** is to improve the health and well being of individuals, families and our communities through innovation and the pursuit of excellence. The ABC's are statements of our values – Accountability, Best Practices, Compassion and Synergy.

- Accountability: Being responsible for meeting the commitments we have made, including ethical and professional integrity, meeting our budget and strategic targets and compliance with legal and regulatory requirements.
- Best Practices: Requires us to make choices to maximize excellence, and to learn from internal and external resources about documents ways to increase effectiveness and/or efficiency.
- Compassion: Serving others with empathy, kindness and respect.
- Synergy: A combining of our efforts so that together we are more than the sum of our parts.

Describe the core members of the PCMH care team in your organization.

At the point-of-care: Primary Care Physician, Nurse Practitioner and/or Physician Assistant, Registered Nurse, Licensed Vocational Nurse or Medical Assistant, Referral Coordinator, Social Worker, Front-office, Medical Records, Refill Clerk

Centrally-located: Medical Management, Information Services, Patient Relations, Quality Improvement, Clinical Operations, Human Resources, Marketing

How do you delineate the respective roles of the medical home and its "neighbors"? We decided to give creative power for practice transformation to each clinical site using continuous process improvement based on LEAN methodology; the clinical sites meet together monthly as a collaborative. A team that includes senior leadership from multiple disciplines negotiates strategic direction and pacesetting.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? We are currently on 2 EMR platforms and consolidating to a shared system-wide EMR platform (EPIC) by end of October. We also have been deliberative about how to message, market and brand PCMH both internally (for our physicians and staff) and externally (for our patients).

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Group visits, On-line portals, Health coaching, Membership on medical group committees

Describe your involvement in a non-clinical community partnership that has been especially successful.
Fit Families partnership with Long Beach Jewish Community Center, Voter registration with Los Angeles County Registrar-Recorder
Doc-Is-In program with Long Beach Jordan High School

Tuesday, October 15th I 1:30 pm – 2:15 pm
Panel 6
Strategies to Enhance Transitions in Care

Many hospitalizations result from care system failures in the transition from various health care settings and providers. This panel will discuss strategies to involve the medical home care team in assuring patients make successful transitions in care throughout the medical neighborhood and community.

Speakers:

- Christine Bechtel, Advisor, National Partnership for Women & Families **Moderator*
- Trent Haywood, MD, JD, Chief Medical Officer, Blue Cross Blue Shield Association
- Carol Henwood, DO, Physician, Stowe Family Practice
- Tracey Moorhead, President & CEO, Visiting Nurses Association of America

Carol L. Henwood, DO
Stowe Family Practice I 555 Glasgow St. I Stowe , PA 19464

PMSI is a physician-owned primary care and multi-specialty group in the Pottsown, PA area. We are dedicated to providing high-quality cost effective care to the patients we serve. At the core of this service is that the team should provide this care while making a difference in patient's lives.

Describe the core members of the PCMH care team in your organization. Physician/team leader/ setting the culture of care delivery in the new model/extending that culture to the non-primary care specialists and other members of the neighborhood by outreach – letting them know that their participation in the patient's care adds to the overall quality of care being delivered.

How do you delineate the respective roles of the medical home and its "neighbors"? All employees/members of the team play an important role. Staff internally and outside PMSI handles referral of patients with careful attention paid to all relevant information being made available to the providers. Among PMSI providers, quality care guides for work up have been developed to eliminate duplicate and unnecessary testing and facilitate rapid diagnosis and treatment of medical problems.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Shared EMR with local hospitals and hospitalists services is available. Patient portals can be used for viewing personal records by patients as well as requesting prescription refills, referrals and communication with the providers.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? Patient report cards with specific goals are given to patents' with chronic conditions at each visit. Group visits for diabetics are held regularly. The patient advisory panel with representation from each primary care site meets three times per year – issues discussed have included medication safety, evaluation of the monthly patient news letter for ease of understanding at the patient level and how to improve patient use of the EMR portals

Describe your involvement in a non-clinical community partnership that has been especially successful. Partnering with a local grocery chain to increase EMR portal use. When a patient accesses the portal they receive a discount coupon for healthy foods at the grocery store.

Tuesday, October 15th | 2:15 pm – 3:00 pm
Panel 7
Value-Based Purchasing in a Triple Aim World: The Employer Perspective

This session will bring together employers and health purchasers to identify payment reform and care delivery innovations that will support the widespread adoption of the medical home, advanced primary care, and accountable care models among large and small employers.

Speakers:

- Chris Campbell, Vice President, Health & Benefits Division, Cragin & Pike
- Christine Hunter, MD, Chief Medical Officer, U.S. Office of Personnel Management
- Kavita Patel, MD, Managing Director for Clinical Transformation and Delivery, Engelberg Center for Health Care Reform, The Brookings Institution
- John Socha, Executive Director, Health Care Operations, MGM Resorts International
- Burton VanderLaan, MD, Medical Director, Network Effectiveness, Priority Health
- Andrew Webber, CEO, Maine Health Management Coalition **Moderator*

Chris Campbell

Cragin & Pike | 2603 W. Charleston Blvd. | Las Vegas, NV 89102

The Direct Care Health Plan is joint initiative lead by MGM Resorts International with partnership by Cragin & Pike in Las Vegas, NV. Our vision for the plan is: to improve the quality of health care in Southern Nevada, we will focus on two driving factors: (1) Improve the way that quality health care is identified, measured, reported, and compensated; and (2) Restore patient accountability for personal health, while reducing barriers to care.

Describe the core members of the PCMH care team in your organization. Our external team is comprised of 25 local, independent, board certified Internal Medicine and Family Practice physicians plus their respective office staff. Our internal team includes a variety of experienced insurance and benefit professionals, data analysts, marketing experts, physician office liaison, and four medical directors.

How do you delineate the respective roles of the medical home and its "neighbors"? Our PCPs are direct contracted with specific contractual and procedural requirements for which they are paid a much higher level of reimbursement. They are the "quarterback" of our PCMH model and currently can refer to their choice of specialists and other "neighborhood" providers. We are currently in the process of building a more select group of "neighbors" that can better coordinate care with our PCPs and provide enhanced access for our patients.

How is information shared between the medical home team, the patient/caregivers, and other providers of care? Our team provides various points of contact for the medical home team including our Patient Registry, Referral Tools, and our monthly dashboard performance meetings with the physicians and their staff.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? *We provide a wide variety of support tolls and programs including: Paid day off to obtain annual physical; On site health coaching at work; Medically supervised weight loss programs including paid surgical solutions with financial incentives for maintaining lost weight; On site dental care.*

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Christine Hunter, MD

Kavita Patel, MD

The Brookings Institution l 1775 Massachusetts Avenue, NW l Washington, D.C. 20036

The Brookings Institution is a private nonprofit public policy organization devoted to independent research and innovative policy solutions. For nearly 100 years, Brookings has analyzed current and emerging issues and produced new ideas that matter—for the nation and the world. Based in Washington, DC our mission is to conduct high-quality, independent research and, based on that research, to provide innovative, practical recommendations that advance three broad goals: strengthen American democracy; foster the economic and social welfare, security and opportunity of all Americans; and secure a more open, safe, prosperous and cooperative international system.

Describe the core members of the PCMH care team in your organization. In my work on payment reform issues, we have realized that teams can look very different but they must all focus on the patient and should not be disruptive to workflows or patient experience.

How do you delineate the respective roles of the medical home and its "neighbors"? This is an important area but one that is going to be a little different from region to region- the growth of medical home models in oncology, cardiology and other areas has opened the door for a medical neighborhood or a regional ACO model and there should be robust and clear roles for primary care and specialty interaction.

How are patients supported to become active as equal members of the care team to the degree they choose to be involved? As payment models emerge, patients should have better access to information and models such as shared decision-making also allow for increased involvement.

Describe your involvement in a non-clinical community partnership that has been especially successful. A great partnership is a program called Witness for Wellness in South Los Angeles; a faith based partnership with UCLA aimed at increasing awareness around behavioral health in primary care practices.

Burton VanderLaan, MD

Medical Director, Priority Health l 1231 East Beltline NE l Grand Rapids, MI 49525

Priority Health is a not-for-profit regional health plan serving the state of Michigan, with approximately 550,000 members. The core mission of the Health Plan is to improve the health of all the people it serves by providing access to effective and excellent health care. Priority is owned by Spectrum Health, a not-for-profit health system based in West Michigan, which offers a full continuum of health care services. Priority Health has a long history of active support and promotion of patient centered primary care. Over 90% of its membership is linked firmly to a primary care medical home, and for the past 15 years, an effective primary care pay for performance program has been in place to support those practices. Currently, the incentive program represents 15% of total primary care compensation, and includes significant financial support for PCMH infrastructure. Priority Health works closely with these medical homes in measuring all aspects of the Triple Aim – including patient outcomes, the total cost of care and the member experience.

Patient-Centered
Primary Care
COLLABORATIVE