

# Medical Home

## NEWS

## A Research Agenda for the Connected Medical Home

By David C. Kibbe, MD, MBA and Joseph C. Kvedar, MD

In a blog post published December 22, 2008 in The Health Care Blog entitled "The Connected Medical Home," we described the synergy we saw between the efforts of proponents of Participatory Medicine and the Medical Home. Our main purpose was to suggest that both providers and patients are longing for a synthesis that takes the best features of Health 2.0 as consumer-generated health care, and combines these with a primary care medical home model offering personal relationships with health professionals who understand the power of the Web and are willing to use the Internet to improve patient care.

In an increasingly web savvy culture, where health and health care are not only important but are also costing us more in out-of-pocket expenses, it's no great surprise that health care consumers are taking to Health 2.0 web sites and services in droves. However, there are very clear signals that consumers and patients don't want Health 2.0 to substitute for a relationship with their doctors. In fact, just the opposite: they want their doctors to help them understand how to best utilize the new Internet resources, and to guide their experiences to the best sites and the most valuable web services.

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Linda M. Magno, MPA

## The Medical-Dental Home

### Achieving Comprehensive Care for Chronic Illness through Integrating Medical-Dental Care and Data

By Valerie J H Powell, PhD and Franklin Din, DMD, MA

At the heart of a medical home is a practice integrating care across settings and practitioners.<sup>1</sup> A routine assumption has been that the practitioners or clinicians providing care can be characterized as physicians. Today we recognize that this characterization is too narrow. Even within the scope of medical care, medical providers could not only be allopathic and osteopathic physicians (M.D., D.O), they may also be nurse practitioners (D.N.P.). When we consider that an artificial structuring classifies care for the mouth and associated structures as oral health care, delivered by dental providers, and care for the rest of the body as systemic health care, delivered by medical providers, we see that the group of practitioners needed to establish a medical home extends beyond the common classification of medical provider to that of dental providers as well. Medical home initiatives endeavor to put aside poor integration in culture, organization, and financing and to avoid fragmentation of care. The medical home movement recognizes that chronic illnesses, such as diabetes, cardiovascular diseases (including heart disease and stroke) consume a disproportionately large share of overall health care costs, and it strives to design an effective care environment to combat chronic illnesses.

Since diabetes care is recognized as a primary target for quality improvement, the extensive clinical literature describing the interrelationships between diabetes and periodontal disease guides us to an understanding of the urgency of medical-dental collaboration within the framework of the medical home.<sup>2</sup> So far, that collaboration has been viewed as a narrow set of care circumstances where a general dentist needs information from his/her patient's physician, such as glycemic control evidence. If we read the clinical literature carefully we realize that medical-dental collaboration is a two-way street.

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**Editor's Corner**

Raymond Carter, Editor, *Medical Home News*

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**The National Medical Home Summit**

*The Leading Forum on the Development and Implementation of the Patient Centered Medical Home*

**A Hybrid Conference, Internet Event and Training Tool**

The entire content of the National Medical Home Summit, held March 2-3, 2009 in Philadelphia, is now available in a variety of formats. *Medical Home News* was a media co-sponsor of the event.

The most comprehensive package is the full Medical Home Summit Training Program. This includes a set of preconference readings, all available online at no cost; the complete video of the Preconference Boot Camp and the Main Summit, with synchronized PowerPoint presentations from all speakers; and the post conference online exam. Individuals who successfully complete the exam with a score of 70% or better receive a certificate of completion. This content is perfect for corporate training programs and can be purchased at deep group discounts. Four organizations around the country are currently serving as beta sites for this group training model – a multispecialty clinic, an IPA, a medical school residency program, and a State health department.

Alternatively, individuals may purchase just the Summit streaming content in a variety of formats, as well as individual presentations. Details are available on the Medical Home Summit web site – [www.MedicalHomeSummit.com](http://www.MedicalHomeSummit.com).

# Residency Training for the Rural Medical Home

## The Smoky Hill Family Medicine Residency Program

**E**arlier this year, the University of Kansas School of Medicine-Wichita Smoky Hill Family Medicine Residency Program in Salina, KS, announced plans to establish the patient-centered medical home model of care, making it one of the first residency programs in the nation to offer residency training in a medical home environment. The Smoky Hill residency transformation project efforts are supported in part by a \$49,500 grant from the United Methodist Health Ministry Fund. Other financial support has come from the National Health Service Corps Health Professional Educational Linkage, a federal Health Resources and Services Administration grant, community funding from the Salina Regional Health Center, and state funding from the State of Kansas.

The main focus of the transformation will be on full implementation of electronic health records, application of health information technology, increased support for patients in managing their medical problems, improved scheduling innovations, and alternatives to the routine office visit. The Smoky Hill program is already using some of the components of the medical home model. It has merged with the community health system, has an electronic medical record, and manages a diabetes registry. The transformation project will place a heavy emphasis on optimizing the newly implemented electronic health record system and helping physicians use a chronic disease registry to track the progress and outcomes of the clinic's chronically ill patient population. Additionally, patients at Smoky Hill will soon find it easier to see a doctor when they need one. The clinic plans to offer new methods of appointment scheduling, including same-day appointments, expanded office hours, and a "quick clinic" for patients with acute health complaints of a limited scope, such as a sore throat or ear ache.

***"The adoption of the medical home model at the residency level is particularly important, because the office practices physicians learn in residency -- good or bad -- tend to translate into their 'real life' practice upon graduation."***

**Rick Kellerman, M.D.**

For close to 30 years, the Smoky Hill Family Medicine Residency Program has produced family physicians serving rural Kansas communities. The state of Kansas established Smoky Hill by legislative mandate in 1977 following a report noting the severe physician shortage in the state, especially in rural areas. A partnership between the hospital and medical staff in Salina, the Kansas State Legislature and the University of Kansas School of Medicine resulted in the University of Kansas School of Medicine-Wichita Family Medicine Residency at Smoky Hill in Salina, better known as Smoky Hill. The program opened its doors in 1979 and graduated the first residents in 1982.

Until 1990, Smoky Hill was one of the few "1-2" residency programs in the nation (the first year of training was primarily hospital-based in Wichita, with the second and third years in Salina). In 1989, the Accreditation Council for Graduate Medical Education approved moving the first year of training to Salina, a town of nearly 50,000 in North Central

Kansas. Since that time, the program has placed 92% of its graduates in rural communities, more than half in the State of Kansas. As Rick Kellerman, M.D., professor and chair of the Department of Family and Community Medicine at the KU School of Medicine-Wichita noted at the January press conference announcing the new program, "The adoption of the medical home model at the residency level is particularly important, because the office practices physicians learn in residency - good or bad - tend to translate into their 'real life' practice upon graduation."

TransforMED, a subsidiary of the American Academy of Family Physicians (AAFP) that focuses on change management and medical practice redesign, was selected to guide the change process over the next three years. TransforMED itself was inspired by the practice redesign recommendations of the 2004 Future of Family Medicine's report that called for "a financially self-sustaining national resource (to be) implemented to provide practices with ongoing support in the transition to the New Model of family medicine." That "new model" is the Patient Centered Medical Home (PCMH).

***"TransforMED is excited about the opportunity to work with the Smoky Hill Family Medicine Residency program ... because it will help ensure future family physicians are prepared to practice in today's rapidly changing environment of new medical technologies and patient-centered care."***

**Terry McGeeney, MD, MBA**

Based in Leawood KS, the home of the American Academy of Family Physicians, TransforMED acts as a leader and catalyst to generate positive transformations in family medicine and primary care, by using and refining a core group of best practices embedded in the PCMH model. It is led by President and CEO Terry McGeeney, MD, MBA, a board-certified family physician whose 30 years of practice include more than a decade in rural solo practice. Through its own staff and outside consultants, TransforMED provides medical home facilitation, retreats, and tailored training that help primary practices measurably improve in three critical areas: patient care, financial sustainability, and the well-being and satisfaction of the physician and staff.

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## A Research Agenda for the Connected Medical Home...*continued*

On the medical home side, we saw two big challenges for the model. First, the growth in demand for services, fueled largely by growth in chronic illnesses, has already outstripped the demand for both nurses and primary care physicians. We can't train enough professionals to outfit all of the medical homes to this specification. Second, true population management requires sophisticated information systems, and there has been little discourse on physician adoption of technologies routinely used in the population health industry, such as predictive modeling software and disease registries.

What if these two concepts were to collide? We saw the possibility of a Connected Medical Home. Since our earlier writing, which received mostly positive commentary, a new President has taken office, and Washington is on fire with talk of health reform and economic stimulus. Health IT and the medical home are primed to take center stage in the evolution of health reform, most observers would agree. However, there are still many details to be worked out. It is not entirely clear what constitutes the best uses of health IT inside the medical home model, nor how to hold these uses accountable for improved care and lower cost of care, let alone how to connect these with consumer-based technologies and bring both to market at a reasonable price, certainly a prime consideration during a recession and if we expect efficient widespread use.

There is significant debate over the process of certification of EHR technology, required by the HITECH Act, in the process of which some observers have pointed out that tools for consumers, such as PHRs from Google and Microsoft, don't fit in any category described within the HITECH Act. Perhaps most important, our experiences of care coordination and continuity enabled by Web and Internet-connected tools and methods are in their very early stages, with only a few published studies on the effects of patient engagement and a small, although growing, number of anecdotal descriptions.

We propose that Participatory Medicine and the Connected Medical Home should be considered a new domain frontier, worthy of both conceptualization and research. Perhaps the future of primary care depends upon the thoroughness and scientific rigor with which we approach this new area of study, and, of course, how quickly and efficiently we are able to apply what we've learned. What follows is a draft proposed research agenda for Participatory Medicine and the Connected Medical Home; in essence a set of questions that we think ought to be answered in the next few years as a means of helping to direct health care reform in this country.

1. What are the limits of self-care? We acknowledge that most health care is still provided in a "top down" and paternalistic manner, one in which the physician or nurse is the "expert" prescribing to the layperson. This model is no longer a good fit in our culture where medical literacy is high and growing, and where the Internet and the Web provide easy access to data, information, and knowledge. But how do we know when self-care is appropriate, will work better than the status quo, and which technologies are most important for self-care to succeed? Here are several more specific questions that lend themselves to investigation:
  - a. Can communications and monitoring technologies increase those limits? How, and through what mechanisms?
  - b. Does it make sense for patients with straightforward chronic conditions such as hypertension to be making some of their own medication dosage and titration decisions (aided by remotely monitored data)? As an example, the management of uncomplicated hypertension is algorithmic in nature. Could we equip patients with some of those algorithms and monitor their progress online? If this is successful with hypertension, what other chronic illnesses might also be amenable to self-care with IT support?
2. What are the components of monitoring for Participatory Medicine that are most impactful in moving patients to healthier behaviors and in encouraging persistence? We, at the Center for Connected Health, recently completed a trial showing that daily contact with an avatar coach resulted in steady state adherence to an activity regimen, whereas individuals who did not have access to the coach had a significantly lower adherence to the program. What are the right circumstances in which to employ non-human coaches? What other technologies (text messaging, interactive voice response, software and games) can be employed in this manner?
3. How do we segment populations in order to know which interventions are most appropriate for them? The corollary is how do we find people who are completely disengaged in their health and move them to at least 'sign up' for an engagement program? Can participatory medicine tools help? Perhaps this is the place where the tools of behavioral economics and choice architecture intersect with participatory medicine.
4. What is the power of the social network as a coaching tool and for which patient segments?
  - a. We (JKvedar and colleagues) recently published an article (<http://archderm.ama-assn.org/cgi/content/full/145/1/46>) showing that psoriasis patients who were part of online social support groups had a self-reported higher quality of life. Others, including PatientsLikeMe ([www.patientslikeme.com](http://www.patientslikeme.com)) have made a number of claims and observations regarding the power of social networks as tools for behavior change and improved care.
  - b. Can one's Facebook friends, in aggregate, be one's health coach? I.e., if we were to publish your health physiologic information on Facebook along with your goals, would your network encourage you to do better and would that make a difference? Can this sort of coaching replace traditional outbound phone calling of the disease management type?
  - c. How much can we push this phenomenon? When, truly, is the wisdom of crowds more effective than the wisdom of an individual provider? Is a social network where an MD is 'in residence' and participating in the discussion more powerful than one that is non-MDs only? Will having the expert in attendance be viewed as a benefit (trusted resource) or an inhibitor (lurker/stalker)?

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**A Research Agenda for the Connected Medical Home...continued**

- d. What is the best way to represent the coaching power of a social network in the electronic medical record? In the PHR?

There will undoubtedly be follow on research questions as we sort out the answers to those above. However, we feel that substantial progress on these questions will move the field forward and give providers more comfort in the utility of participatory medicine as a tool to help them manage populations of patients. There may be critical research questions we missed, and we welcome feedback. A big question is: who will fund this research agenda?

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**The Medical-Dental Home ...continued**

Because the American Diabetes Association, since 2008, has been including dental history and dental referral as an element of their Standards of Care for diabetes, we know that a physician should refer a patient diagnosed with diabetes to a dentist for a checkup, including, by implication, a periodontal screening. If we consider the patients' needs based on relevant clinical findings, a general dentist or periodontist who diagnoses periodontal disease should refer his/her patient to the patient's physician for diabetes screening.

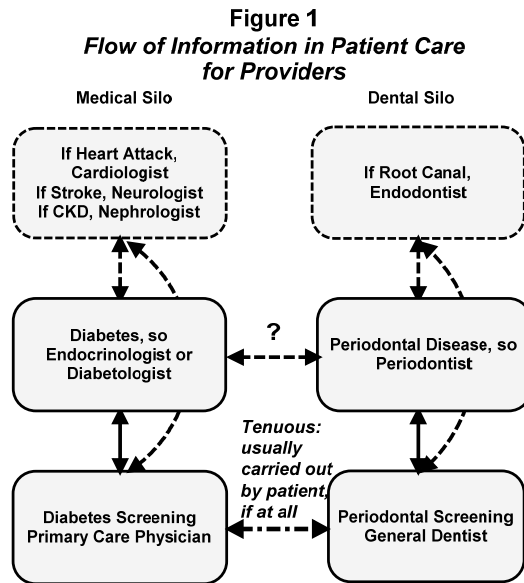
To imagine the seriousness of periodontitis within the context of patient care in general, Professor Edward P. Heinrichs (Periodontics and Preventive Care, School of Dental Medicine, University of Pittsburgh) suggested comparing the aggregate "open wound" of periodontitis (dentogingival epithelial surface area or DGES), according to an authoritative source (Hujoel et al. 2001)<sup>3</sup>, to an open wound ranging (on the mean) from 1.24 sq. in. to 3.1 sq. in.

Yet, how does the information about diabetes and periodontal disease screening enter the patient's respective medical or dental record? Do the registries developed to serve the Patient-Centered Medical Home (PCMH) support both medical and dental care? How easy is it for the patient's medical or dental provider to have a complete health record for the patient? Since both medical and dental providers administer and prescribe medications, it is important for both clinicians to know what medications a patient is taking and what patient conditions or diagnoses might contraindicate certain medications.

As an example of the benefits of medical-dental collaboration, osteonecrosis (death of bone due to insufficient blood supply) is an adverse reaction to biphosphonate medications (used to treat osteoporosis) and (called osteoradionecrosis) to radiation therapy. A dentist will be the first to note the condition and the ability to review a full medical record including diagnoses, medications, and procedures is the only way to determine whether biphosphonate medications or radiation therapy contributed to the condition. If a patient with head or neck cancer undergoes radiation therapy with a significant radiation dose to the mandible, any dentist planning surgical procedures affecting that patient's jaw needs to be aware of the procedure to avoid "post-radiation dental manipulations."<sup>4</sup>

A patient's dentist is often the first clinician to recognize a systemic problem. If there is collaboration of medical and dental care, patients can benefit from by the ability of the dentist to recognize a systemic problem early from oral manifestations. For instance, a herpes outbreak can initially manifest as an oral sore. If you view HIV as a chronic disease amenable to the medical home concept, signs of HIV exacerbation can manifest as oral disease first, like oral candidiasis. Dentists can also screen for the eating disorder bulimia, which leads to oral manifestations obvious to a patient's dentist. Proper oral health generally improves a patient's ability to follow beneficial dietary regimens (fresh vegetables are difficult for people with painful dentitions). Once dental problems are treated and removed as a comorbidity to a systemic medical condition, maintenance of dental health is easy and straightforward at the same time that improvements in systemic health are gained. Dentists can also assist in recognizing Sjögren's syndrome.

Please examine Figure 1 above. Note that communication between the general dentist, who normally does the initial periodontal screening, and the specialist treating diabetes or stroke is typically indirect, proceeding through the Primary Care Physician (PCP) via the chart, EHR, or more likely on the patient's own initiative. Any medical specialists (endocrinologists, cardiologists) treating a patient are ordinarily dependent on the patient's primary care physician for contact with the providers in the same patient's dental silo.



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## The Medical-Dental Home ...continued

A neurologist, for example, who might gain in the processes of diagnosis and treatment from a well-established model of interdisciplinary medical-dental communication, is dependent on the referring PCP for dental silo information, and that referring PCP might not have a direct channel of communication with the patient's dental provider(s). Figure 1 shows a dotted line (labeled with a question mark) for possible communication between an endocrinologist or diabetologist and periodontist. It is easy to see that the medical home goal of completeness is well served by having a complete health record or registry supporting comprehensive medical and dental care.

Unfortunately the two silos both lack a systematic approach to communication with each other unless, in an individual practice, the provider teams (physician and nurse in the medical silo and general dentist and dental hygienist, who has a preventive and patient education role in care, in the dental silo) happen to have mobilized to include seeking a patient's other-silo information in the process of patient assessment. In general this connection must also be regarded as tenuous, as reflected in the dot-dash line.

The arrow in the diagram might suggest that the communication is provider to provider and often, the cross communication, in reality is dental provider via patient as active carrier of the message to the medical provider. The education base for each respective silo does not prepare providers for this particular dimension of care.

A well-established model for efficient communication among medical and dental providers caring for the same patient does not exist in general. Drs. Jim and Rose Geist, University of Detroit Mercy, have designed and evaluated structured forms in their research.<sup>5</sup> A structured interdisciplinary communication form is also used by the Wisconsin Diabetes Advisory Group.<sup>6</sup>

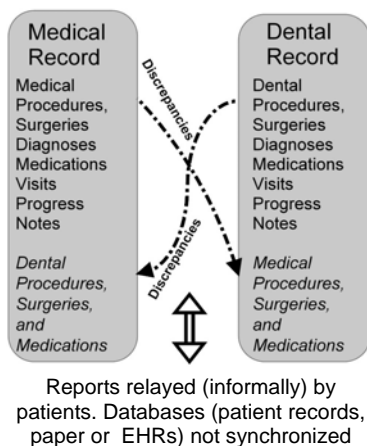
There are barriers to such integration and the medical home movement should insist on appropriate support for comprehensive patient care. The medical home movement has worked against the barriers posed by current physician payment systems, and its advocacy is needed to assure comprehensive care for patients with chronic illnesses. The existence of distinct insurances for oral and systemic health care, leading to separate claim streams, hampers the development of regional and statewide registries and impedes biomedical research. It also poses technical barriers to comprehensive patient management technology.

Since we are in a period of development of the National Health Information Network (NHIN), it is vital that the standards development and harmonization bodies (such as the Certification Commission for Health Information Technology (CCHIT) the Health Information Technology Standards Panel (HITSP), the American Health Information Community (AHIC; now National eHealth Collaborative (NeHC), and Health Level Seven (HL7)) be made aware of the need for integrated medical-dental care and data to support quality care and patient safety.

If the medical home movement does not take action to articulate these needs to HHS/ONC and the relevant standards organizations, EHR support for comprehensive care may be delayed and impeded, and medical home practices will not be able to obtain the EHR systems required to support comprehensive, integrated care.

The current technology supports fragmented care and will not be improved without effort to raise awareness of the clinical reasons for improving NHIN design to assure comprehensive care support. The failures in the past of CCHIT, HITSP, and AHIC/NeHC to acknowledge the requirement for comprehensive care for patients with chronic illnesses have been verified.

**Figure 2**  
Health Records in Silos  
Can Compromise Quality and Safety  
through Inconsistencies/Discrepancies



The medical home movement could play a major role in achieving improved, integrated EHR technology. Given the needs of chronic illness care and preventive care, EHR products based on the fragmented model of care are already obsolescent. Research reports beginning as early as 1977 have documented discrepancies (see Figure 2) between medical and dental records for the same patients.<sup>7</sup>

If the NHIN provides for a synthesis of medical and dental data to support optimal patient care, a suitable, efficient interdisciplinary communication model is required. However general interdisciplinary agreement on the nature of such communication does not exist and thus is not available to support the education of medical and dental providers. When a periodontist receives a patient referred by a general dentist, it is clear what information should be sent to the referring dental provider. That same information, however, might not be meaningful or useful to a referring primary care physician or endocrinologist providing care for a patient with diabetes. A collaborative medical-dental approach to care would also lead to reciprocal best practice concepts for screening, such as the opportunities for dental providers to screen for eating disorders or oral cancer or for medical providers to screen for oral health as suggested by a number of sources. Providers in both silos sharing care of patients need accurate information on medications prescribed in the other silo (blood thinners, antibiotics, pain medications) and on certain tests ordered in one of the silos. Haughey et al. (1998) reported that "the joint use of patient record systems avoided discrepancies in patient information which would have affected the quality of patient care" and "joint consultations reduced the need for secondary referrals."<sup>8</sup>

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## The Medical-Dental Home ...continued

According to Haughney et al., "the pilot study had revealed, [for 178 joint patients] in a retrospective study, a large number of discrepancies between information contained in the medical records summary and the medical history in dental records."

It is clear that we now have two streams of care, medical and dental, both with prescription and administration of medications and surgical procedures affecting the same patients, without adequate articulation. Such a circumstance of fragmented care clearly does not support quality of care or patient safety and also has risks for liability. The last was underscored by a 2008 \$3.9 million settlement in a case where a patient undergoing an endodontic procedure died in part because of failure of the providers to "get a proper medical history from [the patient] before putting her under sedation...."<sup>9</sup>

In conclusion, integrated EHR technology is a support for and driver of comprehensive, integrated health care services. Examples of current medical-dental integration in the U.S. are provided by the Indian Health Service (IHS), the Department of Defense AHLTA system, and the Department of Veterans Affairs Vista system. The Indian Health Service diabetes Standards of Care<sup>10</sup> (SoC) call for a dental exam, including screening for periodontal disease. These standards point out that "[p]eriodontal (gum) disease, an infection of the supporting tissues of the teeth caused by specific bacteria, is a common complication of diabetes. Therefore, adults with diabetes are at increased risk of periodontal disease. Among AI/AN adults with diabetes, advanced periodontal disease occurs at rates two to three times higher than for individuals who do not have diabetes. Infections associated with advanced periodontal disease can interfere with an individual's glycemic control and can actually cause blood glucose levels to rise." While the IHS had an EHR including both medical and dental, they feel the SoC together with the integrated EHR provide a more consistent approach to integrated care within the service. Most Community Health Centers (CHCs) rely on co-location of medical and dental services. Examples of CHC comprehensive patient management integrating medical and dental services for diabetes care can be found in CHCs such as La Casa Health Center<sup>11</sup> in Portales, New Mexico, and the Marshfield Clinic system based in Marshfield, Wisconsin. Marshfield Clinic has developed an integrated EHR to support integrated care. The Department of Defense Tricare deems dental record information vital for quality diabetes care of active duty and retired military personnel and relatives.

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## Thought Leader's Corner

Each month, *Medical Home News* asks a panel of industry experts to discuss a topic suggested by a subscriber. To suggest a topic, send it to us at [info@medicalhomenews.com](mailto:info@medicalhomenews.com).

### ***Q: How important will it be for future medical home development to be able to show that the medical home model generates real, well documented cost savings?***

"Quality and cost-effectiveness are the keys to a high-performing health system. Evidence suggests that a well-constructed medical home model is one way to achieve both. Comprehensive health care reform should include more use of the medical home – as well as other models that emphasize comprehensive, patient-centered care management – to improve patient quality and ease costs across the board."



**Honorable Max Baucus**  
United State Senate  
Washington, DC

"Over time, it is very important for the medical home model to show real cost savings. In the short term, however, the medical home can suffer from unrealistic expectations. Buyers of healthcare services are craving to achieve immediate value for their investment, but the gains may not be realized until we have rebuilt, reorganized and refinanced our primary care delivery system. I believe, over time, we will achieve gains in cost savings and in improving health through the medical home model. The evidence is indisputable, in the US and other countries, that good primary care, when part of a meaningful patient-physician relationship, is linked to better health and lower cost."



**George Chedraoui**  
Healthcare Leader  
Immediate Past President, Bridges to Excellence  
IBM  
Raleigh, NC

"The obvious answer to this broad question is "yes". But if there is anything we've learned from care management evaluations over the years, it's that the issues and questions are nuanced. Assuming we've defined the definition of savings, we need to know what aspects of the programs work (what aspects are required, which are superstition, which need to be improved?), for which populations, over what timeframes, etc? In short, we need ever greater precision."



**Michael S. Cousins, PhD.**  
Vice President, Program Evaluation  
CIGNA  
Bloomfield, CT

"How important? Imperative! Physicians and the medical home staff need to feel an almost missionary zeal to prove that greater attention to patients' preventive health needs and better guidance of individuals and families struggling with chronic medical problems can both improve the quality of care our health system delivers and reduce costs. With costs skyrocketing and health care becoming unaffordable by government, as both Medicaid and Medicare head for bankruptcy, as well as by employers and patients, none of us has the luxury of just trying new ideas. We must make them work to address both quality and affordability. I think a prime goal must be greater patient involvement and responsibility for health. We must creatively educate and inspire patients to become skilled health managers to reduce the use of high cost care. Technology can help us, but it is focus, commitment and collaboration that will get us there. As the design of care delivery must change to better support patients, so the design of insurance plans must change. Affordability of drugs for a diabetic should not be the issue. A patient's willingness to adopt the discipline of care that reduces complications and hospitalizations over time should be the issue. Such value based insurance designs are improving health and saving care dollars and will work perfectly with medical homes. Change requires change!!! And the medical home is a crucial change because it has the power to change how we all, care givers and patients, work together to improve health ...and save money!"



**Nancy Johnson**  
Senior Policy Advisory  
Baker, Donelson, Bearman, Caldwell & Berkowitz  
Washington, DC

**Thought Leader's Corner** ...continued

"It will be pivotal. Physicians want to be paid a higher fee for their medical home work, but it is going to be very difficult to persuade private payors (self-insured employers, union trusts, private insurers) to spend more money, even for better quality. Medical homes are going to fall in one of three buckets, with very different responses. If they provide better quality but with higher costs, there will be few takers. If they increase quality and offset their higher fee with an equal reduction in downstream spending (ER visits, hospitalizations, specialist consults), the payor response will be favorable, but lukewarm. If quality increases and per member per month cost actually decreases, after accounting for the higher physician fees, medical homes will thrive. What's most likely? It's a perfect moment for well-controlled trials, which is why Medicare's medical home demonstration is so important. The evaluation design is robust, and hopefully care will be taken to tease out the ingredients that are associated with better clinical and payer financial outcomes."



**Arnold Milstein, MD**  
National Health Care Thought Leader, Mercer  
Medical Director, Pacific Business Group on Health  
San Francisco, CA

"Affordability is the number one issue for health care. The expectation of the medical home model is that it will provide patients with accessible, appropriate care that promotes health and avoids waste in the system. This can be achieved in a variety of ways including providing access and reducing emergency room visits; reaching out to patients to provide them with preventive services and needed screenings; using electronic prescribing and medication reconciliation to avoid drug interactions; teaching patient self-management and avoiding hospitalizations and supporting considered approaches to end-of-life care. The future of the medical home model depends on being able to demonstrate that investment in primary care will result in reduced unnecessary services systemwide as well as high quality care. To achieve this, we need better communication and coordination between primary care physicians and sub-specialists and between physicians and facilities. We need to integrate individual practices into this larger network and payment systems that reinforce this value."



**Phyllis Torda**  
Senior Executive, Strategic Initiatives  
National Committee for Quality Assurance (NCQA)  
Washington, DC

"Right now, our efforts to implement medical homes and fundamentally transform to a more effective delivery model are largely based on faith. While there is reasonably compelling evidence from pilot projects, from comparative studies of international health care systems with a strong primary care foundation, and from evaluation of the variation in practice in different regions and communities in America, the evidence base which would allow a dispassionate observer to conclude that this model for the delivery of health care definitively delivers either better or less expensive care has not yet been established. Early adopters (this commenter included) find the virtues of PCMH compelling, and health plans are currently participating in demonstration projects to establish how best to move forward. For now, it is imperative that we thoughtfully and objectively evaluate existing and future projects so we can establish an evidence base on which to make informed decisions about resource allocation. If PCMH is to migrate from a novel approach to a dominant model for delivering care, its proponents must convince those who ultimately pay for health care – employers, governments and, ultimately, people – that either (a) this model delivers care at a lower overall cost or (b) the value it delivers is worth any incremental cost in the short-term. The self-evident virtues of this approach to primary care will only get us so far."



**Don Liss, MD**  
Medical Director, Mid-Atlantic Region  
Aetna  
Blue Bell, PA

"Clearly, as with disease management, medical homes increase quality and provide more resources for patients. However, the savings claims are more than dubious. The most frequently cited study, which Mercer Management Consulting performed on North Carolina's program, found more savings just in North Carolina Medicaid than in all other published results for disease management and medical home programs in the other 49 states combined, excluding the tens of millions of dollars which Mercer has also found for savings in state disease management programs they have reviewed, like Pennsylvania. The clear lesson so far is: Whether for disease management or medical homes, if a state or employer wants to publicly demonstrate that they saved a lot of money, they should call Mercer."



**Al Lewis**  
President, Disease Management Purchasing Consortium International, Inc.  
Founder and Past President, Disease Management Association of America  
Wellesley, MA

## INDUSTRY NEWS

### HealthData Management

#### Patient Empowerment/Consumerism Important?

In an April HDM reader poll with 233 responses at press time, 41% said these were "Issues that my organization needs to pay more attention to" and 39% said they were "Real developments that my organization is gearing up to handle." 20% called them "Overblown trends that my organization isn't seeing a lot of."



#### IBM, OU Medical School Launch EHR Pilot

In its first medical home pilot with a medical school, IBM announced on April 9 a new research and demonstration partnership with the University of Oklahoma (OU) School of Community Medicine to build the IT infrastructure for medical homes for their primary care practice. The medical school is already committed to the medical home model in its curriculum, research, and practice. IBM will deliver secure information exchange technologies, electronic medical records designed for medical home processes, and an electronic health record and portal that can be used by patients, clinicians, and insurers. IBM and OU will also collaborate on designing and implementing new health analytics platforms to derive new value from the integrated clinical, financial, operational, claims, and genomic data.



#### Swedish Medical Center Opens Medical Home

In March, the Swedish Medical Center in Seattle, WA opened a new primary care clinic which they described as one of the first in the nation to be designed from the ground up as a medical home. The Swedish Community Health Medical Home will serve a broad range of patients and will rely on a monthly fee for payment, similar to a health club, for both insured and uninsured patients. In this way, administrators hope to free physicians from insurance-related issues in order to provide 30-60 minute office visits with patients. For self-pay patients the fee is \$45 per month for an individual, \$85 for a family of two, and \$35 for each additional family member. The fee covers all visits, phone calls and email contacts, as well as point of care tests done in the clinic, such as blood sugar and cholesterol levels, and preventive care, such as vaccinations. There are no co-pays. Patients will be encouraged to secure more traditional coverage for specialty, hospital, and emergency care, however. The clinic, which will serve as a Family Medical Residency training site, will be staffed by two family medicine physicians, six family medicine residents, and a team of nurse case managers and ancillary personnel. They acknowledge the big question is whether they might be overwhelmed by the demand.



#### Consumer-Based Principles for the Medical Home

On March 30, the National Partnership for Women & Families, on behalf of a coalition of 26 national and regional consumer, labor, civil rights, and advocacy groups, released a set of nine principles for the medical home from the consumer perspective. AARP, the AFL-CIO, Consumers Union, Families USA, the NAACP, the National Council of La Raza, and the national diabetes and Alzheimer's associations were among the groups signing on to the principles.

Among other things, the principles place the patient at the center of the care team, note that different health professionals can serve as the team leader, require that a member of the clinical team be always available by phone or email if not in person, and expect help from the team with insurance eligibility and appeals, cultural and linguistic competence, and a facilitator rather than "gatekeeper" role. The complete document is available at the National Partnership web site at [www.nationalpartnership.org/medicalhome](http://www.nationalpartnership.org/medicalhome).



#### New York Announces \$60M for Medical Home IT

In mid-April New York Governor David Paterson announced the release of a third round of \$60 million in HEAL NY funds to support IT projects in patient-centered medical homes. The Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY) was adopted in 2004 with up to \$1 billion to improve the health care system in the State. A total of \$53 million for HIT was awarded in 2006 and another \$106 million in March 2008, with a primary goal of promoting EMR systems.



#### MedPac Discusses Shared Decision-Making

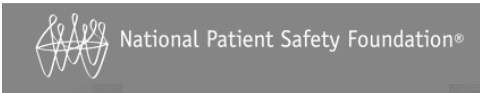
At its April 8 meeting, the Medicare Payment Advisory Committee (MedPac) discussed a staff presentation on the concept of shared decision making in Medicare. Pioneered at Dartmouth-Hitchcock Medical Center in NH and now in use at Massachusetts General Hospital in Boston and several multispecialty group practices in Washington State, the concept involves patients taking a more active role in understanding and deciding treatment options. Like the medical home, however, the model requires more primary care physician time, for which there is no specific compensation under the current fee-for-service Medicare payment system. The topic will be revisited as part of a plan to develop a chapter on shared decision making for MedPac's 2010 reports to Congress. (*Somewhere, Jay Katz is smiling – Ed.*)

**INDUSTRY NEWS**



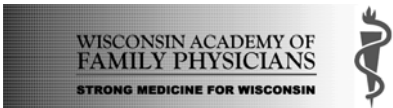
**BCBS Michigan Adds 10% PCMH Bonus**

Blue Cross Blue Shield of Michigan will reward doctors in recognized patient-centered medical homes with a 10% bonus. The health plan, Michigan's largest with 4.7 million members, will also publicize 1,000 physicians who have qualified for the highest level of medical home designation as a way of driving patients to higher quality primary care practitioners. Over the past five years, Blue Cross Blue Shield of Michigan had given out \$100 million in performance payments to doctors in primary care practices to promote and reward adoption of the Patient Centered Medical Home (PCMH) model. About 3,800 primary care physicians are focusing on at least one element in the PCMH program. The 1,000 early adopters who have made the most progress in transitioning to the PCMH model will be designated as Patient-Centered Medical Home practices by the plan. The new 10% bonus payments take effect in June 2009.



**New Universal Patient Compact™ Unveiled**

As part of National Patient Safety Awareness Week, the National Patient Safety Foundation released the Universal Patient Compact™. Building on the Patient Bill of Rights, the new mutual agreement reinforces the importance of a partnership between patient and provider. The idea for the new statement emanated from a roundtable discussion at the 2007 McKesson Nursing Leadership Congress. The "Principles for Partnership" in the compact include 14 specific responsibilities that the patient and the healthcare partner pledge to fulfill, respectively. The patient side emphasizes honesty, inquiry, active participation, and regular communication about any changes. The clinician responsibilities emphasize inclusion, respect, listening, and full disclosure. The compact is on the NPSF web site at <http://www.npsf.org/paf/compact.php>.



**Wisconsin Family Physicians Promote the PCMH**

The Wisconsin Academy of Family Physicians (WAFP) has a comprehensive initiative underway to promote the medical home. WAFP is promoting legislation to create a pilot Medicaid program under which NCQA recognized medical home practices would receive enhanced fee-for-service payments for office visits plus a fixed monthly per member per month (PMPM) care coordination payment. The WAFP web site also provides a wide variety of resource materials to help physicians understand the medical home concept, earn recognition, and communicate with other physicians who have already implemented key medical home components. See [www.wafp.org/pcmh](http://www.wafp.org/pcmh).



**Medical Home for Medicare Advantage Members**

MetCare, a Florida health plan serving about 35,000 Medicare Advantage customers in 19 counties, last month announced the appointment of a new medical director with EMR experience to help them implement a medical home model for their members. William H. McCoy III, M.D is the new associate medical director responsible for the EMR and medical home initiatives. He held previous senior positions with McKesson, Siemens' Shared Medical Systems, the Bard Group, and Forum Health. MetCare recently implemented an e-prescribing initiative with its primary care network of over 400 physicians.



**PCP Views on Access to Mental Health Care**

An article in the April 13 online issue of *Health Affairs* notes that two-thirds of primary care physicians (PCPs) said they could not get outpatient mental health services for their patients in 2004-2005. The study of 3,400 PCPs found 66.8% unable to get "high quality mental health outpatient services" vs. 33.8% for "high quality specialist referrals" and 29.8% for "high quality imaging services." (PCPs could report they were unable to get more than one service.) The major barriers were lack of providers and inadequate or no insurance coverage, both cited 59% of the time. Just behind at 51% were health plan networks and administrative requirements. Pediatricians were more likely to report problems with lack of providers. PCPs in states with mental health parity laws reported fewer problems with coverage and administrative barriers but slightly more problems with lack of providers, suggesting that parity may well increase demand. (Look for a future article on mental health and the PCMH – Ed.)



**Inadequate Preventive Care for Adolescents**

Only 38% of children 10 to 17 years old had a preventive care visit in the last year, according to a study published last month in the American Academy of Pediatrics online journal, *Pediatrics*. Money and lack of insurance were the main reasons. Even when visits occurred, however, they rarely met even minimal standards of preventive care. UCSF researchers asked whether doctors counseled about dental care, eating, exercise, seatbelts, bicycle helmets, and secondhand smoke. Only 10% of adolescents with visits were counseled on all six. (A future article will look at PCMH adolescent care – Ed.)



## Catching Up With ...

**Linda M. Magno, MPA — Director, Medicare Demonstrations Group, CMS, Baltimore, MD**

Linda Magno has been at the Center of Medicare experimentation dating back to the design of the original prospective payment system. She now heads the group overseeing 25 active demonstration initiatives at any given time involving about 300,000 beneficiaries and over \$3 billion in Medicare program payments. She talks about her experiences, her favorite projects, the MMHD, and a little about herself.

### Linda M. Magno, MPA

- Director, Medicare Demonstrations Group, Centers for Medicare and Medicaid Services, Baltimore, MD (since 2003)
- Managing Director for Policy Development, American Hospital Association, Washington, DC (1998 -2002)
- Director of Policy Development, American Hospital Association, Washington, DC (1993 -1998)
- Director of Regulatory Affairs, American Hospital Association, Washington, DC (1988 -1993)
- Director, Division of Hospital Payment Policy, Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services (HHS), Washington, D.C. and Baltimore, MD (1985 -1988)
- Director, Division of Medicare and Reimbursement, Office of Legislation and Policy, HCFA (1984 -85)
- Alcohol, Drug Abuse, and Mental Health Administration Administrator's Award for Meritorious Achievement; Secretary of HHS Distinguished Service Award; HCFA Administrator's Citation; Bureau Director's Citation
- AB Degree University of California, Berkeley, Phi Beta Kappa; Master of Public Affairs degree, Princeton University

**Medical Home News:** *You have been involved in a lot of previous Medicare demonstrations. Any favorites?*

**Linda Magno:** That's a bit like asking a mother who her favorite child is, so the short answer is no. One of the most satisfying aspects of working in demonstrations is that each one is different. That means I have an opportunity to engage in continuous learning about the health care industry and to think about how new technologies might be deployed to improve the care of Medicare beneficiaries. And virtually all of the demonstrations I've been involved in have taught us something. Much of the time, that something is less about the hypothesis the demonstration was designed to test and more about our beneficiary population and its needs, about the complexities of the Medicare program and the many interrelated systems that must be modified or worked around to get some demonstrations off the ground. As a colleague of mine often said, "In demos, we have to fly the planes we build." And seeing a demo that we've built get off the ground successfully is tremendously satisfying.

**Medical Home News:** *The results of the disease management demonstration were clearly disappointing to everyone involved, and yet there are useful lessons in all experiments. What do you think are the "take aways" from that experience?*

**Linda Magno:** Out of the seven demonstrations we have conducted over 35 sites, I think our key learnings are: (1) For disease management to work (and by work, I mean improve outcomes and reduce costs), there must be behavior change on the part of physicians and/or beneficiaries. And behavior change is really difficult. (If it were not, this nation would not be facing the obesity epidemic it's facing.) And even if disease management programs succeed in changing behavior around the conditions on the basis of which beneficiaries were targeted for these programs, it's still not clear that they could generate net savings to Medicare because about half of the hospitalizations were for conditions other than the targeted conditions. (2) Medicare beneficiaries trust their doctors. If disease management or care coordination programs are not integrated into physician practices or are not endorsed by a beneficiary's own physician, they are unlikely to have an impact on either beneficiaries or their physicians. (3) Integrating disease management into physicians' practices and face-to-face contact with beneficiaries may be necessary conditions, but they are not sufficient to guarantee success. (4) The fact that an intervention is intuitively appealing is no guarantee that it will work. And the cost of adding a new service or benefit to Medicare, even for a small fraction of beneficiaries, is so high that evidence of the value of such a service or benefit must be demonstrated.

**Medical Home News:** *Has the change in Administration slowed down the Medicare Medical Home Demonstration (MMHD)?*

**Linda Magno:** MMHD continues to move through clearance, but because the medical home has gained such attention in the health care reform debate and represents a potentially important shift in the way primary care is organized and paid for, we will want to be sure the new Administration is comfortable with the demonstration design and evaluation plan before we go live.

**Medical Home News:** *This month's Thought Leader question asks how important it will be for the medical home movement going forward to demonstrate real, well documented savings. What is CMS's perspective?*

**Linda Magno:** There is no reason to believe that the elderly and disabled of this country are better served by having Medicare pay more for the same kind of care they are getting today. So I think it is critically important for the medical home to demonstrate real, well-documented savings. This is true whether we are looking at the medical home as a means to improve payment for primary care physicians and make primary care more attractive to graduating medical students or as a means to restructure the organization and delivery of primary care to improve quality and outcomes of Medicare beneficiaries (and other patients). The Medicare program needs little help spending additional money on behalf of its beneficiaries; the trick is getting value from additional expenditures through programs that pay for themselves.

**Medical Home News:** *Finally, tell us something about yourself that no one would be likely to know.*

**Linda Magno:** While my work in health policy has been tremendously rewarding, it has sharpened my sense of humor, with the result that my real career aspiration is to be a member of the Capitol Steps. [A wonderful, satirical revue company – Ed.]