SCOTTSDALE INSTITUTE

INSIDE IE EDGE

June 2008
Volume 14, Number 5

The Medical Home: IT Revives a Decades-old Concept

EXECUTIVE SUMMARY

Welcome to your new Medical Home. First designed in the 1960s for the integrated care of pediatric patients, it has been updated with the latest digital technology and elements of the Chronic Care Model for the early 21st century, just in time for post-2008 election healthcare reform. It even has room for RHIOs and HIEs. Reimbursement is an issue, as always, but the medical home concept has caught the eye of employers, policy makers and legislators who are increasingly pushing demonstration projects aimed at changing the way healthcare is delivered and paid for.

In its simplest terms, the medical home provides a model for patient-centered, comprehensive and integrated care coordinated by the patient's personal physician, which is typically a primary care physician but can be a subspecialist if a practice provides all of the same services. It's as intuitive as the small-town, family doctor many of us grew up with, but sophisticated enough for providing evidence-based care including preventive care, chronic care and disease management in an era of unsustainable cost trends. And it's being spurred on by IT, because integrated care relies on integrated information. The Patient Centered Medical Home (PCMH) model supported by the primary care physician societies provides one roadmap for practice evolution from practice-specific registries and basic implementation of technology solutions to HIT-enabled practices with fully implemented EHRs and community extensions such as the HIE.

The medical home faces many hurdles. In addition to the major issue of reimbursement/payment model, the primary care physicians who act as the quarterback of care are in short supply. Also, while we've learned a lot in recent years about the benefits of managing chronic illness, which has similar elements to the medical home, there's little data on implementation of the medical home model in the larger framework of healthcare. But that's changing quickly as we found by talking to a physician executive at the American College of Physicians, an HIE consultant and executives at Group Health Cooperative, Kaiser Permanente and HealthPartners. Because the latter three are HMOs, they are demonstrating medical-home-like strategies to which many employers, policy makers and legislators are paying attention.

Defining the medical home

"The definition of the medical home has evolved," says Michael S. Barr, MD, MBA, the American College of Physicians' VP of practice advocacy and improvement. The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for coordinating care for children with chronic conditions. In 2002 the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered,

Scottsdale Institute Conferences 2008-2010

Fall Conference 2008
Hosted by Northwestern Memorial Hospital
Sept. 25-26, 2008
Chicago

Spring Conference 2009
April 29-May 1, 2009
Camelback Inn,
Scottsdale, Ariz.

Fall Conference 2009
Hosted by Texas Health Resources
Sept. 24-25, 2009
Fort Worth, Texas

Spring Conference 2010
April 14-16
Camelback Inn,
Scottsdale, Ariz.

Fall Conference 2010
Hosted by Intermountain Healthcare, Salt Lake City, Utah

SCOTTSDALE INSTITUTE

Membership Services Office:
1660 Highway 100 South
Suite 306
Minneapolis, MN 55416
T. 952.545.5880
F. 952.545.6116
E. scottsdale@scottsdaleinstitute.org
W. www.scottsdaleinstitute.org

For information on any of these teleconferences, please register on our Website www.scottsdale institute.org

July 25
Business Intelligence (BI): Opening the Floodgates
- Jeremy Bikman, VP, Research, KLAS Enterprises, Orem, Utah

July 28
Clinical Decision Support at Robert Wood Johnson: A Case Study
- John Chuo, MD, MS, medical director, Neonatal Intensive Care Unit, director, Neonatal Informatics, assistant professor, Pediatrics, Robert Wood Johnson Medical School, Bristol Myers Squibb Children's Hospital, New Brunswick, N.J.

July 31
Advocate Clinical Decision Support Case Study
- Joel S. Shoolin, DO, MBA, VP, Advocate Health Care, Oakbrook, Ill.

August 6
Information Sharing within a Federated Data Model—Enabling Data Collaboration without Compromising Security
- Jamie Welch, CIO, Louisiana Rural Health Coalition (LRHC), Baton Rouge, La.

August 13
Clinical System Benefit Measurement Metrics: How to Select, Collect and Report
- Doug Thompson, principal, Strategy Expert, CSC, Fall Church, Va.

more events on next page

coordinated, compassionate and culturally effective care. (The PCMH—defined through the NCQA-supported Patient-Centered Primary Care Collaborative—does not require an EHR. Its basic form includes a patient registry that is ideally electronic but could be paper. For more detail see the paper at http://aappolicy.aappublications.org/cgi/content/full/ pediatrics;110/1/184).

The American Academy of Family Physicians (AAFP) and the ACP have since described models based on the early description of the medical home for improving patient care called the "future of family medicine" or the "advanced medical home" respectively.

Michael Barr, MD, VP, American College of Physicians, Washington, DC

ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

"It's a way of organizing medical care at the micro-systems level based on the Chronic Care Model, and now referred to by some as the Care Model since the principles and attributes work for all people—not just those with chronic conditions," says Barr. In March 2007, prompted by senior-level executives from IBM, who questioned why they could purchase medical-home-type healthcare in other countries but not in the United States, the primary care physician societies—ACP, AAP, AAFP and the American Osteopathic Association (AOA)—created the Joint Principles of the Patient-Centered Medical Home:

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. [A detailed framework includes separate fee-for-service payments for face-to-face visits, which raises the larger question of reimbursement and incentives touched upon later in the report by Kaiser's John Mattison, MD]

The Joint Principles are fleshed out in detail on the ACP website at http://www.acponline.org/advocacy/?hp. A description of the PCMH is at http://www.acponline.org/advocay/where_we_stand/medical_home/overview.htm.

The medical home concept has gotten the attention of policy makers.

A report by ACP and The Commonwealth Fund on the incremental cost of building and maintaining the medical home is expected out later this year. Also, Health Affairs will devote its September/October 2008 issue to the medical home. More importantly from the reimbursement perspective, CMS will launch the Medicare Medical Home Demonstration project in 2009 in up to eight states. The payment model described in the legislation includes a care-management fee and a shared-savings model patterned after the physician group practice demonstration project. See CMS Link at: http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1199247&intNumPerPage=10 and PDF at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_TaxRelief_HealthCareAct.pdf

in particular 204(b)2; and section E re: payment/shared savings.

North Carolina's Medicaid managed care program provides each recipient with a medical home and a primary care provider who coordinates that recipient's care and is accessible day or night. The key feature of the North Carolina project is the establishment of a care-coordination network to support the practices; each practice did not have to build the capability.

And big employers like IBM continue to support the concept. "This wouldn't be happening if employers weren't behind it," says Barr. "The Patient-Centered Primary Care Collaborative grew out of an initiative by the medical professional societies and major U.S. employers and now has over 130 endorsers representing more than 50-million people." (www.pcpcc.net). There are several demonstration projects involving multiple commercial payers and other interested parties as documented on the PCPCC website.

Ironically, the concept behind the medical home may outlast the term itself. AAFP-sponsored focus groups have found that, while legislators and policy makers have adopted the term "patient-centered medical home," consumers reject it because it conjures up images of nursing homes, funeral homes and hospice care. On the other hand, patients like most elements, especially the idea of a personal physician. Such considerations will be important if the medical home concept is to take roost in the near future.

Group home

For the past two years, Group Health Cooperative, a Seattle-based, consumer-governed, nonprofit HMO that serves more than half a million residents of Washington and Idaho, has been drowning under a deluge of clinic patients.

"We knew the primary care workload was becoming unsustainable," says Michael Erikson, primary care administrator for Group Health who oversees 25 clinics in Washington state and northern Idaho. Staffed by nearly 300 physicians, those clinics provide care to 360,000 patients, assisted by about 1,000 RNs and LPNs, 65 physician assistants and nurse practitioners as well as IT, laboratory, pharmacist and business operations. "As a result of the increasing numbers of care needs of our population—visits per day, chronic care patients, trying to meet all the needs of patients—docs were slogging through the day," he says.

Group Health seized on the medical home concept as a potential solution to those challenges because primary care historically provided the core to its integrated multi-disciplinary group practice. "We've always been committed to a primary care model, so we came back to our identity. But we emphasized that it had to be sustainable and had to have traction in the market," Erikson says. "We're all struggling with how to live with the current model of health care as well as reform healthcare. We asked, 'Is the patient-centered primary care model really the model to bring sustainable change to healthcare?'"

Group Health's medical home incorporates three spheres: 1) Family practice; 2) General internists; 3) Pediatrics. Specialists receive patients through the medical home and support the primary care physicians in coordinating care but are not the specific focus of the medical home.

Group Health's version of the medical home is built on five principles:

Upcoming Events continued

August 14
Realizing Budgetable Benefits: RAD Voice Recognition
- Robert C. Weeks, director, Information Services Division, Memorial Hermann Healthcare System, Houston

August 26
Revenue Cycle Reformation: Will Software Solutions Keep Up?
- Kent Gale, president, KLAS Enterprises, Orem, Utah

September 9
A Balanced Scorecard Approach to Developing an Integrated Enterprise Data Warehouse
- Narayanan Kulasekar, manager, EDW/Business Intelligence, Advocate Health Care, Oakbrook, Ill.
- Tina Esposito, MBA, RHIA, director, Center for Health Information Services, Advocate Health Care, Oakbrook, Ill.

September 16
Hospitals Subsidizing Community Physician EHRs, Tax Implications for Both Parties
- Linda Sauser Moroney, partner, Drinker Biddle Gardner Carton, Chicago
- Jennifer R. Breuer, partner, Drinker Biddle Gardner Carton, Chicago

September 17
Oncology Solutions: A Complex Area—Who is Hitting the Mark?
- Jeremy Bikman, VP, Research, KLAS Enterprises, Orem, Utah

For information on any of these teleconferences, please register on our Website www.scottsdale institute.org

1. The patient is at the center of all the organization does. The relationship of personal care physicians and patient provides the focus for care. "The entire care team will organize and align itself to support this focus," says Erikson.
2. Primary care physician is the leader of the care team, "the hub of the wheel."
3. The continuous healing relationship will be proactive and encompass all aspects of health and illness. "This works exceedingly well with the electronic medical record (EMR) where we know a great deal about preventive and planned care needs often before the patient does, and we can engage the patient proactively," he says.
4. Access is focused on the patient's needs and is available 24x7. "This will maximize the value of the EMR that interfaces with MyGroupHealth website, which allows doctors and patients to interact in a secure on-line environment and have a continuous conversation with regards to all aspects of their care," says Erikson.
5. The organizing principle for all clinical and business systems, including lab, pharmacy and radiology, and medical subspecialist is aimed at achieving the most efficient and effective execution of the medical home. "Many systems fracture because they're in silos. The medical home is integrated in all aspects," he says.

A year and a half ago, in conjunction with its Group Health Center for Health Studies, an independent, non-profit research arm, Group Health launched a two-year pilot to determine if the medical home could show improved quality (HEDIS measures) as well as better patient, provider and staff satisfaction. The study, which involves a single clinic using the medical home model and two control clinics to facilitate comparison, is also evaluating the model's economics, specifically cost per member per month.

Prior to launch of the medical home, Group Health's average panel was 2,400 patients per doctor. For the purpose of the medical home study, the HMO lowered panels to 1,800. "We did not want docs to be reactive but proactive," says Erikson. "What's happened in healthcare is that, because there are fewer primary care doctors, they barely have enough time to see the patient. We knew we had to lower the workload so we could expand the five to 10-minute visit to 20 or even 40 minutes so physicians could be comprehensive."

Prior to the pilot, Group Health physicians were seeing 22 to 24 patients a day on average—a relatively low figure nationally—but the organization lowered it even more to 14 to 16 visits a day for the medical-home clinic. That allowed doctors enough time not only to see individual patients face-to-face but to also communicate with them using secure messaging or phone visits—and to conduct group visits for certain types of patients. "They're not doing less clinical care; they're doing more and all indications it's being done more effectively too," says Erikson. "Also, the physician is able to do rounding when patients happen to need facility-based care. So, the doc now has the capacity to know both her panel's chronic-care and preventive-care needs. This is what gets missed in reactive, high-volume practices—the comprehensive view."

Group Health's model incorporates a 1:1 "flow-staff"-to-doctor ratio, or one medical assistant per physician. These assistants help with many aspects of follow-up care—what HMOs call panel management.

Kudos

Thomson Reuters 100 Top Hospital awards recognized SI members for their results in management and clinical outcomes.

For the 10th time *Munson Medical Center,* Traverse City, Mich. has won the National Benchmarks for Success Award.

Five-time Cardiovascular Benchmarks for Success Award winners are: *Hackensack University Medical Center,* Hackensack, N.J, *Mercy Hospital,* Coon Rapids, Minn., *St. John Hospital & Medical Center,* Detroit, and *UPMC Presbyterian,* Pittsburgh, Penn.

The team has one physician assistant or nurse practitioner per five physicians who help with daily patient-access needs and with planned-care needs that require a higher level of care, like complicated medication adjustments. Two RN-level nurses support physician panels in assisting with transition planning—patients who move from higher levels of care such as hospitalization back to ambulatory care or the reverse.

Those RNs are regarded highly and often share offices with physicians, extending the physician's reach to patients who require complex case management, including patients with diabetes, heart disease, asthma and depression.

Erikson says Group Health invested 10 percent to 15 percent more resources in the medical home clinic than its other clinics, and that interim data is showing a strong return. "Within six months the medical home had paid for itself in reduced lab services, some reductions to selected specialties and reduced ED visits," he says. While the pilot is still active, and data still rolling in, the one-year data show strong trends toward high quality outcomes, increasingly satisfied patients and staff—and a much-lower rate of rise in healthcare costs in the medical home than comparison clinics. If the model holds, Group Health will roll out the medical home to all its primary care clinics in 2009.

Erikson says the pilot is getting a lot of attention locally and nationally, with Washington state legislators evaluating it as a model for the Medicaid program. "A year and a half ago when we launched this pilot, there was percolating interest in the medical home, but not the widespread attention there is today. We said if we can't do this, nobody can. We've got to figure this out. We're glad we did invest in this model of care," he says.

Minnesotans call it coordinated care

"We don't like the term medical home," says Alan Abramson, senior VP and CIO, HealthPartners Inc., a Minneapolis-based integrated delivery network. "We put the medical home into the larger category of the coordination of care paradigm. Most IDNs have been working on some aspect of medical home/coordinated care. We think it involves the relationship continuum between the patient, primary care doctor and specialist."

HealthPartners

Alan Abramson, VP/ CIO, HealthPartners Inc., Minneapolis

HealthPartners has been developing its coordinated care model since becoming involved in the Pursuing Perfection program in 2001, the care transformation initiative funded by the Robert Wood Johnson Foundation and led by the Institute for Healthcare Improvement. HealthPartners has been so successful in using performance measurement to drive improvements in quality and efficiency that last year it won the National Quality Healthcare Award from the National Quality Forum (NQF). Part of the recognition was for the culture of transparency and accountability to patients and the community that HealthPartners fostered, all elements of the medical home model.

Pursuing Perfection helped drive the organization's development of Care Coordination Teams at its HealthPartners Medical Group and Clinics (HPMG&C) and at Regions Hospital. Under this model, the patient's coordinating physician is always in touch with other physi-

Group Health invested up to 15 percent more resources in the medical home clinic than other clinics, but interim data is showing a strong return.

cians and caregivers even if the patient is admitted to the hospital.

"The place where all this comes together is coordination *with* you and *for* you," says Abramson. "The individual patient has an important role for sharing information, especially personal symptoms."

HealthPartners begins with the idea of this ongoing relationship; technology is the enabler. HealthPartners' one million plan members have anywhere/anytime access to a web-based PHR (based on Epic's MyChart) using an ID and password; the PHR offers three customizable tabs—Health Plan, Patient Services and Health & Wellness. Under the health plan tab, for example, a member can change their address, review claims, search providers, verify levels of coverage and compare cost and quality of surgery.

The patient-services tab gives members direct access to 14 online patient services including emailing your doctor, e-visits, refilling prescriptions, test results, immunization records and accessing children's immunization records. The third of HealthPartners' members who go to its own clinics can also schedule appointments, according to Pat Lund, HealthPartners communication director, and the system accounts for 70,000 appointments a year. "About 17 percent have signed up for online patient services and our goal is 40 percent," she says, adding, "Every person who goes to our clinics gets this coordinated care, even those with different health plans."

Ninety percent of HealthPartners' population has access to the Internet, allowing members to call, click or visit providers. "We provide multiple avenues for access, all coordinated through a single primary care physician on the Coordinated Care Team," says Abramson.

HealthPartners targets its Coordinated Care Team resources at those people with chronic illnesses like diabetes or behavioral-health problems. "They are given a card with the phone number of the care coordinator," says Abramson. "That way they have ongoing, frequent connections to the system."

Lund notes each of the organization's clinics has a "Prepared Practice Team" that meets in the morning, reviews all patients and assesses their blood pressure and cholesterol readings. A HealthPartners program focused on closing disparities of care has collected statistics on race and ethnicity and found—perhaps not surprisingly—a wide disparity in care among certain populations. It found, for example, that minority groups are often overlooked for routine screenings like mammograms, so if a woman comes in for a routine appointment, the EHR triggers a reminder to staff to tell the person, "By the way, you're due for a mammogram."

Lund recalls a female plan member who called to make an appointment for a simple head cold and was reminded to come in for a mammogram. At the visit she was found to have early-stage breast cancer. "That's just one example of how the appointment center saved a life," she says.

A home at Kaiser

John E. Mattison, MD, wears a lot of hats at Kaiser Permanente in California, including assistant medical director, CMIO and regional director for KP HealthConnect in Southern California. He's also co-chair of Kaiser's IT Infrastructure governance group and a member of the clinical committee at the Oakland headquarters—and he lives in San Diego. So he's on the road a lot and much of that time his thoughts

"The place where all this comes together is coordination* with *you and* for *you," says Abramson. "The individual patient has an important role for sharing information, especially personal symptoms."

are centered around the medical home, a concept he's been passionate about for a long time.

KAISER PERMANENTE® thrive

John E. Mattison, MD, asst. medical director, Kaiser Permanente, Pasadena, Calif.

Trained in internal medicine and critical care, Mattison has been a trailblazer in the area of IT standards and interoperability, having founded the International Standard Clinical Document Architecture (CDA). Kaiser Permanente is conducting a pilot of the medical home using the Continuity of Care Document or CCD, which is based on the CDA standard. Built upon the HL7 standard and more robust and interoperable than the Continuity of Care Record (CCR), he says, the CCD provides the basis for IT-enabled integrated care at Kaiser by linking together all aspects of the patient's medical record.

Mattison says Kaiser's approach to care has always reflected the medical home concept. "Anybody who's a member of Kaiser Permanente has access to comprehensive services and a single medical record, and over two-million members have already signed up for online services including secure messaging with their personal physicians and a wide range of other online services." All of which is coordinated by a primary care physician—the de facto medical home, supported by 100 percent of Kaiser physicians using the Epic EHR. Kaiser provides such comprehensive, integrated care to all Kaiser Classic members without any additional payment, and it offers it to other fee-for-service, high-deductible customers as well.

"We have clearly succeeded in providing greater access of all physicians to a complete continuous record with decision support for disease prevention and health maintenance," says Mattison, "and we have clearly succeeded in providing online access to our physicians by all members who sign up for online services. These two successes have placed an incredible burden on our primary care docs. As a result, our key focus now is how to distribute the work more evenly over the primary care team so that we create a more sustainable practice for our primary care physicians. This challenge represents our top priority over the next few years, and we have several initiatives, including the Proactive Office Encounter, Population Care Management and HealthConnect optimization. All these initiatives are focused on lightening the load on the individual primary care physician as they increasingly become the hub of all care. The initial results have been highly encouraging, but much work lies ahead of us still."

Mattison cautions that the devil is in the details, especially with payment. He views the trend toward reimbursement for bundled services that support the medical-home as unfortunate. Specifically, Mattison notes that under the otherwise laudable Joint Principles promulgated by the AAFP and other primary care societies, the payment section stipulates the medical home "should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not

Kaiser's success at achieving access for patients and physicians to each other and to a continuous online record has "placed an incredible burden on our primary care docs. As a result, our key focus now is how to distribute the work more evenly over the primary care team so that we create a more sustainable practice for our primary care physicians. This challenge represents our top priority over the next few years."

result in a reduction in the payments for face-to-face visits)."

"You get what you incentivize" he says, and if a physician can enhance revenue with a $75 office visit, or treat a patient with "information therapy" with an email or phone call, there is a clear financial incentive to schedule an office visit. "If the patient wants the convenience of a 'virtual visit' without having to schlep into the office, losing time from work, then the 'bundling' of the medical home payments in this fee-for-service model can be a disincentive to providing the most appropriate care and convenient care," says Mattison. The foundational model at Kaiser Permanente is that the physician should never consider financial issues in deciding the most appropriate care, and the medical home costs are "bundled" with all other services so that there is no financial incentive other than to provide the best care and consider the convenience factor for the patient.

"If the patient wants the convenience of a 'virtual visit' without having to schlep into the office, losing time from work, then the 'bundling' of the medical home payments in this fee-for-service model can be a disincentive to providing the most appropriate care and convenient care," says Mattison.

"The market is going the exact opposite direction," he says. Traditional fee-for-service models of care are finding that they're shifting work from the office to virtual visits through various web-based services. They have a legitimate need to be reimbursed for this work, and it is not represented well in existing fee schedules. Unfortunately, the "bundling" of medical home services in a fee-for-service context simply systemizes the disincentive to provide convenient but "virtual care" services. In the more holistic model where the "bundling" applies to all care, whether in-office or virtual care, the clinician and the patient can jointly decide what is the most appropriate means of managing each clinical event, and the reimbursement model is either neutral—or if anything favors more convenient virtual care and information therapy, he asserts. When the medical home concept becomes defined by a way to augment reimbursement for web services in the fee-for-service world, it paradoxically represents an incentive towards more traditional in-office care, since the opportunity for a fee-for-service visit financially disincentivizes the virtual care which has been bundled into a monthly payment relatively independent of volumes.

Bring on the HIE

Where RHIO/HIEs exist, physicians and provider organizations could direct clinical and other patient-specific information to the patient's medical home, says Jay McCutcheon, principal of Health Network Services, a consulting firm focused on HIEs and RHIOs. The value would be determined by a number of factors, he says, not the least of which would be the breadth and depth of participation in the HIE by those physicians and service-provider entities within the medical trading area (MTA). The medical home model should benefit from participation in the HIE from the connectivity and interoperability that HIEs provide.

The HIE offers utility services, says McCutcheon, for all subscribing service-provider entities and physicians to communicate and manage clinical results/reports, physician-to-physician consults and referrals, as well as orders like labs, medications and other frequent inter-organizational transactions.

"Of course, with the medical home's participation and the consent or directives of the patient all the transactions could be delivered to the medical home as paper, electronic or registry services. There are HIEs developing quite well in Cincinnati, Indianapolis, South Bend and Delaware that could accommodate medical homes. These services would aid all other physician practices in the MTA as well. HIEs help to free the information from the

widely distributed silos of clinical data, communicate it securely to physician and patient-directed locations to reduce the limitations of fragmented, widely distributed and unavailable information for the patient's caregivers throughout the community," he says.

McCutcheon says the convergence of HIEs and the medical home raises some key questions. "Will these HIEs be able to serve the medical homes well as they develop across the country? What other functions or services might a successful HIE be able to perform for emerging medical homes or their successors: EMR interfaces, "EMR-lite" services, coordination or provision of home-based monitoring, delivering a patient's clinical information to a PHR or Health Data Bank? Will areas of the country be served by independent service providers and physicians outside the models of those described earlier? If so, an organization like an HIE may be of considerable service to medical homes. At least, existing RHIO/HIEs and the vendors serving them should consider the needs of a very important new customer in the MTA. Those developing reimbursement plans for medical homes should also consider payment for participation in HIEs. Those working on privacy, security and data use agreements should also be well versed in the needs of the medical home and the patients who depend on them for safety, quality and the review of their complete medical history."

Reimbursement for the medical home will require payment for the patient visit or telephone counsel, and additional forms of payment for communication and coordination with the patients other care givers and family and the patient on an ongoing basis, he says.

Conclusion

The medical home offers a model for comprehensive, integrated care centered around the patient. It requires a team approach that makes the primary care physician the quarterback and coach. While reimbursement does not yet support the medical home concept except in the prepaid managed care sector, with new leadership in Washington, DC, in January 2009, the time is propitious for more effective and efficient models of care. Whether it's ultimately called the medical home or some other term, the demand for comprehensive, integrated care has never been more vocal.

What our members say about our conferences:

"Extremely valuable, lots of Monday-morning value."

"Excellent content. Great opportunity for audience participation and comment."

"I learned a lot from the speakers and the attendees."

SCOTTSDALE INSTITUTE MEMBER ORGANIZATIONS

Advocate Health Care, Oak Brook, IL

Alegent Health, Omaha, NE

Allina Hospitals & Clinics, Minneapolis, MN

Ascension Health, St. Louis, MO

Banner Health, Phoenix, AZ

BayCare Health System, Clearwater, FL

Billings Clinic, Billings, MT

Catholic Health Initiatives, Denver, CO

Cedars-Sinai Health System, Los Angeles, CA

Charleston Area Medical Center, Charleston, WV

Children's Hospitals & Clinics, Minneapolis, MN

Children's Memorial Hospital, Chicago, IL

CHRISTUS Health, Irving, TX

Cincinnati Children's Hospital Medical Center, Cincinnati, OH

DeKalb Medical Center, Decatur, GA

Hackensack University Medical Center, Hackensack, NJ

HealthEast, St. Paul, MN

Heartland Health, St. Joseph, MO

Integris Health, Oklahoma City, OK

Intermountain Healthcare, Salt Lake City, UT

Legacy Health System, Portland, OR

Lifespan, Providence, RI

Lucile Packard Children's Hospital at Stanford, Palo Alto, CA

Memorial Health System, Springfield, IL

Memorial Hermann Healthcare System, Houston, TX

Munson Healthcare, Traverse City, MI

New York City Health & Hospitals Corporation, New York, NY

New York Presbyterian Healthcare System, New York, NY

North Memorial Health Care, Minneapolis, MN

Northwestern Memorial Healthcare, Chicago, IL

Norton Healthcare, Louisville, KY

Parkview Health, Ft. Wayne, IN

Partners HealthCare System, Inc., Boston, MA

Piedmont Healthcare, Atlanta, GA

Provena Health, Mokena, IL

Saint Luke's Health System, Kansas City, MO

Saint Raphael Healthcare System, New Haven, CT

Scottsdale Healthcare, Scottsdale, AZ

Sentara Healthcare, Norfolk, VA

Sharp HealthCare, San Diego, CA

Sparrow Health, Lansing, MI

Spectrum Health, Grand Rapids, MI

SSM Health Care, St. Louis, MO

SUNY Downstate, Brooklyn, NY

Sutter Health, Sacramento, CA

Texas Health Resources, Arlington, TX

Trinity Health, Novi, MI

Truman Medical Center, Kansas City, MO

University of Missouri Healthcare, Columbia, MO

University of Pittsburgh Medical Center, Pittsburgh, PA

Virginia Commonwealth University Health System, Richmond, VA

SPONSORING PARTNERS

INGENIX
EXOGEN
Deloitte.
hp invent
CAREfx
NAVIGANT CONSULTING
KORN/FERRY INTERNATIONAL
CSC EXPERIENCE. RESULTS.
Hill-Rom Enhancing Outcomes for Patients and Their Caregivers.
THOMSON REUTERS

STRATEGIC PARTNERS

KLAS Honest. Accurate. Impartial.
HealthTech