DRIVING VALUE IN MEDICAID PRIMARY CARE: THE ROLE OF SHARED SUPPORT NETWORKS FOR PHYSICIAN PRACTICES

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March 2011

ABSTRACT: The passage of health care reform presents state Medicaid agencies with a historic opportunity to expand health insurance coverage to millions of Americans while redesigning the primary care delivery system to produce better outcomes and achieve better value. One important way in which states can explore new models for effecting practice transformation, especially among small practices serving large numbers of Medicaid patients, is by emphasizing the purchase of shared practice supports for these often underresourced practices. Based on interviews with experts and the authors' policy analysis, this paper discusses the challenges of transforming small primary care practices; how Medicaid can offer shared supports to providers or catalyze them into investing in modernized systems of care; and what else federal and state governments can do to help advance these efforts.

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ACKNOWLEDGMENTS

EXECUTIVE SUMMARY

The Affordable Care Act gives state Medicaid agencies significant opportunities to redesign the primary care delivery system so as to optimize health care value. Small practices in particular, especially those that serve large numbers of Medicaid patients, can benefit from access to a network of shared resources, or "practice supports," that help implement new models of primary care and sustain the transformation process. This paper, based on consultation with national and state experts, key informant interviews, and the authors' policy research, describes how Medicaid can purchase or catalyze investments in such shared practice supports.

Key points include:

Practice supports have diverse manifestations. They may be seen, for example, as resources for strengthening leadership, culture, and the capacity for change; as aids to practices' various administrative and financial functions; and as staffing reinforcements such as shared practice facilitators and nurse care managers.

Medicaid can connect physician practices and deliver shared practice supports in a number of ways. As a significant insurer in most states, Medicaid could use its market power and influence to drive changes in primary care delivery in general and the provision of practice supports in particular. By viewing practice supports as publicly financed "shared utilities," Medicaid could lead in efforts to organize virtual or real networks of physician practices through such trusted entities.

Medicaid and the Affordable Care Act present states with a number of financing vehicles. States have an array of options for funding practice supports, depending on the type of Medicaid delivery systems involved (e.g., full-risk managed care, primary care case management, or fee-for-service) and on whether states want to build such supports themselves, buy them from third parties, or create incentives for physicians to purchase them directly. In addition, states could redesign physician payment mechanisms so as to recognize the iterative process of transformation and reward better outcomes. State Medicaid agencies could pursue such efforts alone, but they should also consider developing or joining existing multipayer efforts.

Other policy opportunities exist in the Affordable Care Act and in current Medicaid statute to advance primary care. The health reform law includes several

vehicles, including provisions on health homes and increased federal funding for primary care, to assist states in developing and financing practice transformation. The Centers for Medicare and Medicaid Services' review of these provisions, as well as of other current and developing policies and regulations, could allow states considerable flexibility in creating and financing shared-support models.

This report develops the above points, and it discusses other potential strategies for Medicaid to purchase and advance high-value primary care, provide shared supports, and build virtual networks that essentially create communities of caregivers in small physician practices. Because they address distinct aspects of practice transformation, numerous provisions of the Affordable Care Act provide additional supports to practices. But it is up to the states to strengthen support for primary care providers by using these provisions in a strategic and coordinated way.

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INTRODUCTION

Primary care is facing a perfect storm. Population growth, an expanding number of preventive services, and the rising prevalence of chronic disease create more demands on the practice of primary care but with little accompanying change to the antiquated and inadequate reimbursement systems now in place.[1] As a result, patients are frustrated with long wait times, providers are dissatisfied with "hamster wheel" medicine based on a high volume of visits, and care is often uneven and inequitable.[2] But because the majority of patient care is still delivered in small primary care practices, it is critical for payers to support the viability and effectiveness of primary care providers in addressing these issues.[3,4]

As the nation's largest health coverage program, spending some $427 billion annually and purchasing care for nearly 60 million individuals in the United States, Medicaid must help lead the way in adopting new models of coverage and health care delivery.[5] Through the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, Medicaid will potentially cover an additional 16 million to 20 million people by 2019, thereby insuring a quarter of the nation's population.[6,7] Given its sheer size, together with its evolution from a bill payer to a buyer of health care coverage, Medicaid has a responsibility to purchase high-value primary care that drives better outcomes, greater patient satisfaction, and the more efficient use of resources. State Medicaid agencies in particular must ensure and invest in an adequate network of providers to cover current and future beneficiaries.

Efforts to transform primary care, such as Pennsylvania's Geisinger Health System and Washington's Group Health Cooperative, often focus on large and integrated health care settings, despite the fact that small practices deliver the majority of patient care.[8,9,10,11] Small practices play an especially critical role in caring for Medicaid's racially and ethnically diverse beneficiaries; for example, more than half of African American Medicaid beneficiaries in Michigan receive care in practices with three or fewer providers.[12] Unfortunately, the quality of care in small practices, particularly regarding the treatment of chronic disease, is often lower than in larger practices.[13] Further, while 31 states are now planning or implementing patient-centered medical home (PCMH) pilot projects in their Medicaid or Children's Health Insurance Program (CHIP) efforts, not all of these undertakings focus on small practices.[14]

Lessons from primary care transformation demonstrations in larger health care systems do not translate easily to small primary care practices, which tend to have smaller staffs, unpredictable demand for services, prohibitive costs, and limited contact with other small practices.[15,16] Those with a large proportion of racial/ethnic minority patients see more patients, depend more heavily on Medicaid for revenue, provide more charity care, and earn less than do practices that see mostly white patients.[17] As a result, small practices often face significant and disproportionate challenges in implementing new primary care practice models and reducing disparities in care.[18,19]

Small practices' problems can be mitigated, however, through connections to shared resources and personnel, especially those professionals with expertise in primary care transformation.[20,21]

In that spirit, this paper explores: a) essential components of practice supports; b) ways in which Medicaid could purchase, or catalyze providers to invest in, such supports; c) how Medicaid could connect physicians who work in small independent practices; d) financing vehicles, whether already existing in Medicaid or enabled by the Affordable Care Act; and e) key policy recommendations for advancing primary care as fundamental to high-performing health systems. Findings are based on policy analysis by the Center for Health Care Strategies (CHCS); its consultation with national and state experts; and key interviews with more than 30 stakeholders, including researchers, providers, and representatives of professional societies and boards, health plans, and Medicaid agencies (see Appendix A).

OVERVIEW OF PRACTICE SUPPORTS

The American Academy of Family Physicians' "New Model of Family Medicine," put forth in 2004, sparked a national debate that produced new primary care models—including the PCMH, the enhanced primary care model, and advancements to the chronic care model.[22,23,24] All of these models rely on team-based, physician-led care bolstered by modern information and care management infrastructures.[25] The models help to enhance access to care, increase care coordination, improve quality and outcomes, and potentially reduce emergency department visits and inpatient hospitalizations.[26,27]

Practice supports that these models typically include are described in Exhibit 1; additional supports, which interviewees cited as critical to small practices serving high volumes of Medicaid patients, appear in Exhibit 2.

Exhibit 1. Practice Supports Established in the New Primary Care Models[28]

Practice Support	Examples
Process changes to improve access and help providers leverage their time and work more efficiently	• Open/advanced access • After-hours and weekend coverage • Telephone and e-mail consultations • Appointment reminders • Practice–redesign • Patient outreach
Clinical decision support to guide evidenced-based decision-making at the point of care and to facilitate population-based care	• Registry reports and panel management for patient tracking and population health management • Electronic systems to order, receive, and track tests • E-prescribing • Clinical data systems that embed evidence-based guidelines • Meaningful use of health information technology and electronic health records • Quality measurement, tracking, and improvement
Changes in the delivery of care to improve quality	• Use of nonphysician staff to manage care • Patient education and self-management support • Motivational interviewing • Care coordination between primary and specialty care • Linkages to community, social, and health services

Exhibit 2. New/Enhanced Practice Supports

Practice Support	Examples
Resources for strengthening leadership, culture, and the capacity for change in order to sustain practice improvement and redesign	• Internal and external motivators to create a culture of change • Practice leadership to garner support for change • Assessment of a practice's willingness and ability to change
Practice management support to help keep administrative functions and finances in order	• Assessments of deficiencies, as well as opportunities for administrative and financial improvement • Electronic financial management and administrative systems (e.g., automated/enhanced provider reimbursement and billing systems) • On-site personnel to train staff in financial management and administrative processes
Access to a range of staffing supports that either help with practice redesign or transform the ways in which practices deliver care	• External practice facilitators or coaches who help physician practices redesign and continuously improve • Specialized health care professionals (e.g., nurse care managers, pharmacists, dieticians, and behavioral health specialists) who can help improve the quality of care via health coaching and chronic disease care management

ENHANCED PRACTICE SUPPORTS FOR MEDICAID AGENCIES TO CONSIDER

Key informants interviewed by CHCS suggested how Medicaid agencies could purchase, catalyze, or finance supports for transformation in small primary care practices that serve large numbers of Medicaid and racial/ethnic minority patients. Most of the interviewees agreed that Medicaid alone should fund the transformation of practices serving large volumes of beneficiaries, and that it should partner with other payers when practices with more diverse patient panels are involved. Six key findings were:

1. Build a culture for change and develop leadership capacity.

2. Build external and internal motivations for change.

3. Provide leadership development.

4. Provide practice management support, which is a critical component of practice transformation.

5. Deploy shared practice facilitators to help in practices' redesign.

6. Embrace the use of team-based care through deployment of nurse care managers and other health care professionals.

The above findings are discussed below:

Practice supports should include the building of a culture for change and the development of leadership capacity, starting with a baseline assessment of capacity levels.

The majority of small primary care practices lack the leadership attributes and change management capability to sustain quality improvement and practice redesign.[29] Interviewees stressed these elements as *the most* important ones for success. The tailoring of interventions also requires an assessment of primary care team members' motivations, external influences, resources, and opportunities for change, as well as the opportunities for interactions among these factors.[30] A number of publicly available practice assessment tools (see Appendix B) can help Medicaid agencies determine leadership and change management capability, and accordingly tailor state-led practice-support programs.

Medicaid can also catalyze the development of physician organizations and motivate its providers to join them. Such organizations often provide the leadership and managerial structure needed to accelerate the modernization of health care services in Medicaid.

Build external and internal motivations for change.
Practices' culture—manifested in their practitioners' beliefs, values, and attitudes—related to change profoundly affects team members' readiness for organizational transformation.[31] Interviewees unanimously agreed that primary care practice models would not be sustainable in practices with low readiness for change. As one informant put it, "You can bring the practice to the pond, but you cannot force it to drink the water." Medicaid agencies thus should identify external and internal motivations for making practice transformation a priority.[32]

Internal motivations for change derive from anticipated enhancements in patient, provider, and staff satisfaction with care. Patients may experience greater satisfaction with care, increased involvement in care, improved quality, and easier access to care. Providers and staff may benefit from reduced stress, enhanced teamwork and employee retention, easier care processes, and increased efficiencies.[33,34]

External motivations for change derive from efforts such as medical home or accreditation programs that can make a practice's transformation financially viable.[35] In addition, it is critical that the local medical community can create peer-to-peer friendly "competition." Peers can be strong motivators for change.

Provide leadership development.
Many primary care providers, particularly those who practice in underserved settings, are poorly trained in leadership skills.[36] Lessons from the National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home illustrate the importance of providers developing leadership skills that are facilitative in nature, as opposed to the more common authoritarian approaches.[37] A true practice leader has a systems perspective, can envision change, and is an expert in (or at least receptive to) change management.[38,39] With such attributes, he or she can better drive change by more ably assessing performance, identifying targets of change, and developing a workable change strategy.

Many professional societies and quality improvement organizations have incorporated elements of leadership development into practice-redesign education and training curricula (see Appendix C). Most of these programs, however, are not tailored to small primary care practices and tend to be limited to online education rather than to continuous on-site education, which can be more effective in high-volume Medicaid practices. Continuous on-site training tools developed and administered by health plans (Appendix C), such as the Group Health Cooperative's Practice and Leadership Development programs, may be of interest.[40] These programs address new clinical

acculturation, leadership development, and patient–physician communication. Others, such as Blue Cross Blue Shield of Michigan's Provider Group Incentive Program, work through professional coaches.[41] These models may be adapted to small practices with high Medicaid volumes.

Medicaid agencies have also developed their own programs for engaging patients and physicians as leaders in practice transformation. For example, Community Care of North Carolina designates one provider in each of its primary care networks as a "physician champion" for promoting redesign to peer practices. In contrast, Pennsylvania's Medicaid agency supports consumers as practice leaders. Through its Pediatric Medical Home program, a parent–patient advocate advises practices on areas in need of change.

Practice management support is a critical component of practice transformation. Interviewees stressed that "getting administrative functions and finances in order" should be an initial focus for primary care transformation. The reason is that efforts to help small practices implement advanced models often fail to ensure that the practices are on stable financial footing in the first place. Small practices, for example, tend to lack accounting and financial management resources, and given high-volume 15-minute patient encounters, the practices' staff members often think they do not even have time for sound financial management. Such conditions make it difficult to meet bottom lines, accommodate patient demand, purchase needed equipment, and accrue savings that would enable practice transformation.

Professional societies and quality improvement organizations have made various financial management, coding, and payment assessment tools, as well as other improvement resources, available online for physician practices (see Appendix D). For example, through CHCS' Reducing Disparities at the Practice Site initiative, Pennsylvania's and Michigan's Medicaid agencies are supporting primary care transformation in small practices by using practice management consultants.[42] Medicaid agencies too can incorporate such on-site technical assistance, along with online resources, into their array of practice supports. And in union there is strength; small and independent practices can benefit from joining a physician network that provides centralized practice management support while retaining their individual practice identities.

Medicaid can also align small practices to contract for technology-based systems that enhance financial and administrative processes. The practices may thus benefit from automated provider-reimbursement and billing-software systems (i.e., practice

management systems) that capture patients' demographic and insurance information, expedite electronic claims processing, support billing and collections, enhance revenue, track productivity, and facilitate internal auditing of services.[43] For example, the California HealthCare Foundation's Small Practice eDesign initiative contracts with local organizations ("aggregators") to support small practices in the adoption, implementation, and use of revenue-cycle management systems, as well as of electronic health records (EHRs) that can improve operational efficiency and clinical quality.[44] In New York, the Primary Care Information Project's quality improvement team employs consultants, whether through on-site visits or off-site training classes, to help participating providers use EHRs to optimize billing processes.[45]

Deploy shared practice facilitators to help practices redesign.
Practice facilitators are health care professionals who work with practice staff over a sustained period of time to help initiate, implement, and sustain redesign activities.[46] Applying their expertise in change management, quality improvement (including plan-do-study-act cycles), and health information technology, practice facilitators assess a practice's needs and its capacity to reorganize and restructure. In particular they can enhance "adaptive reserve" (i.e., a practice's resilience), facilitate implementation of new primary care practice models (such as team-based care), improve quality and appropriateness of care, and reduce costs.[47,48] They also can help with advanced-access scheduling, group medical visits, self-management education, and team-based care. Frequent in-person contact between practice facilitators and staff helps to build the relationships required to sustain change. One interviewee said: "You know a practice facilitator has been successful when he or she can enter the back door of the practice without knocking."

Interviewees recommended that practice facilitators work with multiple practices, visiting each one at least once a week. Medicaid programs in Michigan, North Carolina, Oklahoma, and Pennsylvania that are using facilitators have facilitator-to-practice ratios ranging from 1:2 to 1:15. Through a shared-staffing network, practices learn firsthand from facilitators about other sites' best practices, and they gain access to a resource they could not otherwise afford (see sidebar, below). This learning can even be accomplished formally by bringing communities of small practices together to collaboratively work with change management facilitators, as is done in the Blue Cross Blue Shield of Michigan's Lean for Clinical Redesign Collaborative Quality Initiative.

Medicaid Support of Practice-Based Facilitators

CHCS developed its Reducing Disparities at the Practice Site program to support quality improvement in small practices serving high volumes of racial/ethnic minority Medicaid beneficiaries. The three-year initiative, launched in October 2008 with funding from the Robert Wood Johnson Foundation, is testing the leverage that Medicaid agencies, health plans, primary care case management programs, and other local organizations can exert to improve chronic care in small practices in Michigan, North Carolina, Oklahoma, and Pennsylvania.

In Oklahoma, for example, Reducing Disparities at the Practice Site supports practice facilitation activities within certain small "high-volume, high-value" practices participating in the SoonerCare Health Management Program (HMP). As part of this program, Oklahoma's Medicaid agency contracts with the Iowa Foundation for Medical Care (IFMC) to employ, train, and deploy nurses who serve as practice facilitators for participating primary practices. Through a community-based model for facilitation, IFMC deploys five nurses who each serve two practices.

The practice facilitators help primary care practices develop plans for redesign (based on information about the staff, available technology, and priorities), hold weekly meetings, monitor staff, improve staff communication, and share performance updates. Further, by teaching practices how to implement team-based care, patient registries, and other quality improvement and population management tools, the facilitators enable the redesign.

A recent evaluation of SoonerCare HMP showed that IFMC's practice facilitators were performing required facilitation assessments and completing 100 percent of the expected facilitation activities.[49] In addition, a survey of providers found that a majority reported such activities to be "very helpful" and that over 90 percent were making changes in the management of their chronically ill patients as a result.

Embrace the use of team-based care in practices through deployment of nurse care managers and other health care professionals.

Given the rise in chronic disease incidence, changes in care delivery are needed to better manage patients' health conditions, support patient self-management, and promote wellness.[50,51] Under the traditional primary care model, the often-overtaxed physician tries to meet patients' diverse needs in a variety of ways—through ordering tests, diagnosing, treating, and filling out forms. In contrast, new primary care models incorporate team-based care to create efficiencies and deliver higher-quality care.[52] Because nurse care managers (NCMs), pharmacists, dieticians, behavioral health professionals, and other allied health professionals can complement the physician more fully under such models, states are starting to think creatively about how small practices may share these team members.

North Carolina, for example, integrated practice-based care managers into its Community Care of North Carolina program, producing overall savings for the state's Medicaid agency.[53] Vermont recently developed community health teams that incorporate care managers and other multidisciplinary professionals (see sidebar). States can use practice-based health coaches to support patient self-management and wellness.[54] Practice-based NCMs support chronic care delivery by teaching patients how to make lifestyle changes, monitor their symptoms, connect with community resources, and otherwise manage their disease.[55,56] Finally, for low-income patients with more than one chronic condition, multidisciplinary care teams often include social workers, *promotoras* (community-based liaisons to health organizations), and navigators to provide linkages to a wide range of health, behavioral, social, and community services.

Vermont Blueprint for Health: Pioneering the Use of Community Health Teams

Vermont's Blueprint for Health is a plan to coordinate and support care for patients with chronic conditions. The Blueprint is testing how to integrate specialized-health-services pilot projects—which incorporate health information technology infrastructure and patient-centered medical homes supported by community health teams (CHTs)—into primary care practice in three pilot communities. Participating practices have access to these insurer-funded CHTs, which are multidisciplinary groups of health care professionals that directly support patients/families and work closely with primary care offices, hospitals, and health and social service organizations. The CHTs help the population engage with preventive health services, manage chronic conditions, and improve health outcomes.

Each CHT includes a care coordinator, a behavioral health specialist, a public health prevention specialist, and other specialists as needed. Team members visit multiple practice sites and interface with patients, clinicians, community-based organizations, and other service providers. The team is responsible for helping practices identify and assess at-risk patients' barriers to care, facilitating access to appropriate services for vulnerable populations, improving service coordination, developing self-management plans, ensuring follow-up, and engaging patients in preventive health care.

Vermont's Medicaid agency and private insurers are sharing the costs of the three pilots, each of which has a CHT that includes five full-time equivalents and costs $350,000. The Blueprint has encouraged insurers to shift from contracted disease management services to team-based care, which helps achieve greater financial sustainability by reducing the unnecessary use of acute care services.

The three pilots have reached 12 practice sites, 58 medical home providers, and approximately 60,000 patients by using three CHTs. While the pilots have not been operating long enough for true clinical and financial impacts to be adequately assessed, early data reveal that they are experiencing positive trends in reducing hospitalizations and emergency department visits.[57]

Pharmacists can also participate on the primary care team and in the medical home model by using medication therapy management to address medication adherence issues among the chronically ill.[58,59,60] In addition to performing traditional prescribing and monitoring, pharmacists could contribute to new disease-management functions as well. Medicaid could facilitate this enhancement by supporting electronic pharmacy databases, e-prescribing, and other health information technology (HIT). Connecticut's Medicaid agency is leading such an effort to integrate pharmacy-related HIT, and pharmacists themselves, into primary care services (see sidebar).

Connecticut Medicaid Transformation Grant Demonstration: Pharmacists

Under a Medicaid Transformation Grant from the Centers for Medicare and Medicaid Services, Connecticut is testing a model that uses pharmacists and pharmacy-related health information technology to support the primary care team. The program provides medication therapy management (MTM) services to Medicaid patients with complex needs in order to improve care, medication use, and health outcomes, as well as to mitigate costs for patients with multiple chronic conditions.

The project, called PharmNetEx, aims to: a) build a comprehensive and active medication profile that can be accessed by providers via health information exchanges; b) assess medication-related problems and share findings with patients and care providers; c) advance the medical home concept by using pharmacists' MTM services to optimize medication outcomes and reduce medication-related problems; and d) improve medication adherence by giving providers e-prescription fill data.

PharmNetEx contracts on a fee-for-service basis with provider groups, payers, health plans, and employers to provide pharmacy services in primary care offices. Pharmacists work directly with patients to perform comprehensive medication reviews, develop patient medication and action plans, assess medication-related problems, develop personal medication records, and communicate with the provider.

Since implementation, the program has made encouraging progress, with retention rates for patient visits to pharmacists surpassing 90 percent.[61] Further, surveys have found that patients have felt more empowered to ask primary care physicians and specialists about medications following pharmacist visits.

Because behavioral health disorders are so prevalent among Medicaid beneficiaries, states like Massachusetts (see sidebar) are exploring ways to better integrate primary care and behavioral health care. Depending on the acuteness of patients' conditions, primary care teams are testing new models such as: 1) colocation of behavioral health providers in primary care practices; 2) colocation of NCMs in community mental health centers in order to better treat patients with severe mental

health conditions; 3) rotating or on-call support for physicians from psychiatrists, who may assist, for example, with medication management; and 4) support for patient adherence and self-management from a care coordinator.[62,63]

The Massachusetts Child Psychiatry Access Project

The Massachusetts Child Psychiatry Access Project (MCPAP) was developed to: a) improve the access of primary care providers to child psychiatry consultation services; and b) support referrals to mental health specialists.

MCPAP costs Massachusetts $3.2 million annually to operate, with funding provided by the Department of Mental Health through a contract with the Massachusetts Behavioral Health Partnership, a managed care organization responsible for managing the Medicaid behavioral health benefits for Medicaid enrollees in the state's primary care case management program.

MCPAP deploys six regional behavioral health teams across the state to work directly with local primary care providers. As of July 2009, 365 primary care provider practices in Massachusetts were enrolled in the program. Each regional team includes 1.0 full-time equivalent (FTE) child psychiatrist, 1.5 FTE licensed clinical social workers, 1.0 FTE care coordinator, and appropriate administrative support. The psychiatrist (or clinical nurse specialist) responds to telephone consultations from participating primary care providers. The clinical social worker is responsible for clinical assessments, transitional therapy, and occasional primary care provider consultation as well. The care coordinator facilitates referrals, communicating with families to match needs and preferences with available therapists or psychiatrists.

Since implementation, MCPAP has achieved encouraging outcomes, successfully enrolling virtually all pediatric primary care providers in the state and showing early positive trends in the satisfaction scores of primary care and mental health providers and consumers.[64]

Given their limited resources, small primary care practices could benefit from state Medicaid agencies' deploying teams of specialized health care professionals to rotate among a set of practices, triaging them based on the volume of patients and the seriousness of the condition. Medicaid could also catalyze the development of physician networks that use their own team of allied health professionals to collaborate with practice staff. The Affordable Care Act could assist Medicaid in these efforts through grant funding for community health teams that support primary care practices, or for states' use of such teams in the health home. As suggested in the sidebar on Vermont, that state's Blueprint for Health in particular offers a model for other states to consider.

HOW MEDICAID CAN CONNECT PHYSICIAN PRACTICES AND DELIVER PRACTICE SUPPORTS

As the largest insurer in most states, Medicaid can use its influence to drive changes in primary care delivery such as the provision of practice supports. Five key strategies include:

1. View practice supports as shared utilities that could be publicly financed.

2. Organize virtual or real networks of physician practices.

3. View physician networks as building blocks to accountable care organizations.

4. Contract with a trusted entity to provide shared physician supports.

5. Contract with organizations viewed most favorably as trusted entities.

View practice supports as shared utilities that could be publicly financed.

While Medicaid may require contracting health plans and physicians to meet certain performance requirements, long-underresourced practices need help to achieve the specified improvements in care. Medicaid could offer this aid through additional payments to physicians or via practice supports to be shared among physicians. Such a shift in network development and care management could help Medicaid transition from a passive bill payer to an active purchaser of high-quality primary care.

Organize virtual or real networks of physician practices.

Small practices, particularly those in underresourced areas, often operate in isolation. But facilitating linkages among practices in order to improve them could essentially replace this "cottage industry" with virtual networks of physicians. Such networks could establish a culture centered on high-quality care delivery, create a learning community of peers, offer community-based support, and provide a common target for Medicaid support.

Interviewees agreed that virtual networks should at first be bound both geographically (i.e., within walking distance) and socially (i.e., include physicians with similar values and norms). They disagreed, however, on whether network participation should be mandatory or optional and on whether funding should come from Medicaid or the participating physicians, respectively. Informants in the latter camp maintained that physicians need to self-identify and aggregate voluntarily for the network to be truly effective and that the physicians themselves should pay to participate in the network, prompted by incentives from payers (as structured both in the Blue Cross Blue Shield of Michigan network and the Physician "Pod" network in the Adirondacks region of New York).

Other interviewees wanted to encourage the speedy aggregation of providers to produce better results. For example, Oklahoma Medicaid is piloting health access networks (HANs), which may include university-affiliated organizations, county medical provider associations, or private corporations. Oklahoma Medicaid requires that physicians associated with each HAN participate in the network's quality improvement activities.

In the end, the optimal strategy may be an "arranged marriage" in which Medicaid connects physicians on the basis of shared values and expertise, contracts for a set of physician support services, and finances the network with payments both to the physicians and the networks themselves. Over time, Medicaid could create tiered reimbursement for those practices that joined physician networks, while refraining from doing so for those that did not. Savings produced by these more organized systems of care could be used to finance such enhanced reimbursement—a strategy that would compel faster adoption among practices.

View physician networks as building blocks to accountable care organizations.
State Medicaid agencies want models for high-quality and efficient care. One existing model is managed care, which currently enrolls the majority of Medicaid patients; and another is traditional fee-for-service, which includes many of the more complex and high-cost patients. Meanwhile, some states are looking to accountable care organizations (ACOs) as an alternative model of care that requires a strong network of physicians with similar values related to quality improvement, performance excellence, and cost efficiency.[65,66]

ACO models rely on organized physician practices and their connections to hospitals to form a local entity that is accountable for quality and cost.[67] Most often, ACO models look to multispecialty groups, integrated delivery systems, or independent physician associations to form the heart of the organization, which can ultimately be extended to include independent local practices.[68] Virtual networks of independent practices that invest in shared practice supports and have a common vision of improvement are necessary building blocks of a long-term ACO strategy.

Contract with a trusted entity to provide shared physician supports, "letting form follow function" in the contract.
Most interviewees agreed that Medicaid itself should not provide shared physician supports but instead contract with a physician network or other trusted entities to do so. Such entities typically have physician leadership, a long-term community commitment,

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and a true understanding of practice settings. Given the heterogeneity of local health care markets, the physician supports structure will look different in each community. Interviewees universally suggested that form should follow function: states should develop service requirements (e.g., quality improvement, case/care management, health information technology) for networks and the qualifications needed to perform them. By contrast, states should not specify the type of organization with which to contract.

Contract with organizations viewed most favorably as trusted entities.
Interviewees perceived physician organizations (POs) as having the experience, knowledge, and leadership to assist practices with transformation. Blue Cross Blue Shield of Michigan built POs upon the vestiges of the Independent Physician Practice Associations (see sidebar), whereas New York is creating new POs in its multipayer medical home program in the Adirondacks region. Legal challenges to creating new POs can be limiting, however, especially if they would be providing clinical services through nurse care managers, pharmacists, or mental health professionals.

Alternatively, local medical societies and foundations with practice-based quality improvement experience are seen as entities that physicians trust, but they still need to build operational capacities to support small practices and to link with national parent organizations (the American College of Physicians or the American Academy of Family Physicians, for example). Regional networks, such as those in the Robert Wood Johnson Foundation's Aligning Forces for Quality program, that have gained physician trust and built organizational capacity are also well positioned to play the trusted-entity role.[69]

Quality improvement organizations (QIOs) with ambulatory quality improvement expertise, as well as Medicaid's external quality review organizations (EQROs) with quality improvement or practice-coaching experience, are viewed too as potential trusted entities. However, the degree of such perspective varies across the country, and neither the current Medicare QIO program nor the Medicaid EQRO programs are structured to abet practice-supports work. Current examples of such trusted entities include: 1) the California Medical Association Foundation, which is supporting small and underresourced practices in diabetes care; 2) QIOs such as Qualis Health and Quality Partners of Rhode Island, which are implementing medical homes in various practice settings; and 3) the Iowa Foundation for Medical Care.

Most interviewees doubted that health plans could be trusted entities, as physicians do not trust them; however, health plans *can* be catalysts for and funders of practice supports. Leading commercial plans (such as Blue Cross Blue Shield of

Michigan) and Medicaid health plans (such as LACare, CareSource, CareOregon, and Monroe Health Plan) are already playing this role. Interviewees had neutral reactions to Regional Extension Centers (RECs) because of their limited experience to date; however, because of their focus on electronic health record adoption and use in small practices, the role of RECs could be expanded with appropriate staff and expertise.

**Blue Cross Blue Shield of Michigan: Provider Group Incentive
and Patient-Centered Medical Home Programs**

In 2004, Blue Cross Blue Shield of Michigan (BCBSM) created organized systems of care through its provider group incentive program (PGIP), offering incentives to independent physician practices to form physician organizations (POs). Through the POs, small practices remain independent but work collaboratively, share information, learn about quality improvement efforts, and access BCBSM resources. The health plan encourages the natural development of POs through factors such as geography, hospital affiliation, and referral patterns. Currently, the PGIP program includes some 100 physician groups representing 8,100 providers and 1.8 million BCBSM members.

BCBSM's contracts with POs define the types of shared supports provided but allow flexibility in *how* they are provided. Shared supports include population management, quality improvement and performance measurement, and establishment of patient-centered medical homes (PCMHs). POs can also participate in quality improvement initiatives for specific areas of care, each with financial incentives for population-level performance improvement in efficiency and quality. Providers affiliated with a PGIP-participating PO can join the BCBSM PCMH program, which supports and rewards incremental progress in transitioning to a PCMH model.

BCBSM encourages POs to support practices by providing: 1) financial incentives to POs for developing and implementing core capabilities of the PCMH model in their practices; 2) higher office visit fees for PCMH designation; and 3) augmented fee-for-service payments for care coordination.

The results of a rigorous 2010 evaluation of the PGIP-PCMH program are not yet available, but 2008 results indicated that PCMH-designated practice units had 12.3 percent fewer emergency room visits and 11.3 percent fewer inpatient discharges than nondesignated practice units.[70]

Conceptually, Federally Qualified Health Centers (FQHCs) could provide practice supports to independent local physicians. However, many interviewees believed that cultural and mission differences, as well as mistrust, between FQHCs and private practices would impede this possibility, at least at first.[71] Such incompatibilities might be overcome in time as a result of modestly framed collaborative efforts (e.g., contracting to provide practice management or care management services without "stealing" patients).

Finally, although a few interviewees noted the potential for community or public hospitals to provide practice supports, most believed that hospitals are no longer natural connecting points for physicians and also that these institutions face their own staffing and infrastructure challenges. However, given the role of community hospitals and FQHCs in serving currently uninsured individuals who will be covered through Medicaid or state-based exchanges, as well as the role that community hospitals could play in building ACOs, interviewees suggested that leaders at these institutions establish linkages with small and independent practices as building blocks for future ACOs. Physicians in FQHCs, public hospitals, and small practices could join together to create new organizations capable of responding to ACO funding opportunities.

MEDICAID FINANCING OF PRACTICE SUPPORTS

States have multiple (but not necessarily sufficient) options to fund practice supports via Medicaid, depending on the Medicaid delivery system involved (e.g., full-risk managed care, primary care case management, or fee-for-service). Options are also driven by a state's inclinations as to building such services itself, buying services from a third party, or demanding physician outcomes that could drive the practitioner to purchase services directly. While tight state budgets will limit matching funds or upfront funding for practices, Medicaid policies may be reexamined in light of health care reform. For example:

States can use demonstration waivers to cover initial costs of practice supports and physician networks.
A few states have applied for Medicaid 1115 demonstration waivers, which allow them to provide upfront investment for practice supports and physician networks, with assumed savings over a five-year period. It should be noted, however, that a state might experience a timeline challenge when applying for a waiver. For example, Oklahoma's Health Access Networks required more than a year of negotiations with the Centers for Medicare and Medicaid Services (CMS) before receiving such funding.

States can increase rates to managed care organizations (MCOs), require MCOs to fund practice supports directly, or require them to establish physician incentive programs.
States operating full-risk managed care programs via MCOs can increase capitation rates to health plans and require that the extra funds be used for practice supports or provider incentives. For example, Pennsylvania increased its MCO capitation rates by 2 percent so as to create provider incentives around common clinical areas. The state's Medicaid agency is also working with health plans in the Philadelphia market to provide standardized supports (including registries, practice coaches, and practice management

assistance) and incentive payments to practices. Under CMS guidance, however, provider incentives combined with incentive payments to the MCOs cannot exceed 105 percent of the MCO capitation rate.[72] To work around this limitation, health plans could provide direct practice supports beyond the incentive payments.

States can use their EQRO or state medical professionals to provide practice supports with enhanced federal matching options. Further CMS guidance on these options is necessary for states to use them optimally.

EQROs are required to assure compliance with federal managed care regulations, validate managed care performance measures, and certify performance improvement projects undertaken by managed care entities; EQROs can also undertake a variety of optional quality assurance activities. Whether they are mandatory or optional, all EQRO activities receive a Federal Medical Assistance Percentage (FMAP) of 75 percent. For EQROs to help provide practice supports, current regulations would have to be revised to reflect a quality improvement rather than a quality assurance mindset. But states could meanwhile use their EQRO contractor to provide some practice-level support services such as practice coaching, performance measurement, and quality improvement. For example, Oklahoma used its EQRO vendor to offer practice coaching in its Health Management Program. In addition, some states have hired practice coaches as skilled medical professionals, for whom they could also receive the 75 percent federal funding. According to interviewees, however, CMS guidance on these options is unclear, leaving states hesitant to use enhanced federal matching options for fear of CMS audits. CMS could issue clarifying guidance in this area to states.

Because states with primary care case management or fee-for-service programs have limited upfront financing options for shared practice supports, they should capitalize on Affordable Care Act opportunities.

North Carolina has a decade-long history of investing in physician networks and supports via Community Care of North Carolina (CCNC), its primary care case management program. CCNC provides care coordinators who are shared among practices, and it delivers quality improvement and performance measurement support via its networks. But states entering this area only recently, and that would likely have difficulty securing upfront funding because of current state budget environments, can utilize health reform provisions to increase payment levels and enhance payment methods across inpatient and ambulatory care, as well as to redirect resources to primary care. New York, for example, recently redirected $600 million from hospital inpatient care to outpatient care at hospital clinics, community health centers, and independent physician practices in order to build medical homes.[73] Notably, while the Affordable Care Act may provide some upfront financing, much of it is only available for a restricted time.

Instead of building and explicitly funding practice supports, states could provide enhanced funding to physicians to purchase shared supports directly.
Several interviewees recommended that state Medicaid agencies not build state-level support infrastructures but instead offer funding to practices so that they can decide for themselves which support services to purchase. Putting the locus of control in the hands of the provider makes him or her more likely to overcome low levels of motivation and consequently engage in practice transformation work.

Health care reform also includes federal funding in 2013 and 2014 to pay Medicaid primary care providers at rates equivalent to 100 percent of Medicare (compared with the national average 2008 fee-for-service rate of 66 percent for primary care services).[74] In states with currently low payment rates, these increases will be significant and could be used to reengage the physician community in practice transformation as well.

States should pursue physician payment redesign that recognizes the iterative process of transformation and ultimately rewards better outcomes.
One payment model will not be sufficient. Therefore state Medicaid agencies should consider implementing various models tailored to the cycles of practice transformation.[75] Most interviewees noted that a blended form of fee-for-service, capitation or global payments, and performance-based incentives would combine the strengths (and avoid the weaknesses) of current models. Most states, however, simply increase care management fees based on the level of medical home or practice transformation achievement. For example, New York is paying an additional fee of $2, $4, or $6 per member per month, based on the various levels of the National Committee for Quality Assurance (NCQA) Physician Practice Connections PCMH.[76] Oklahoma is similarly paying practices with tiered payments, based on its own PCMH standards of practice capabilities and type of patient panel.[77]

Alternatively, states could vary the payment model to reflect the target level of practice transformation and reward physicians commensurately at different points along the improvement continuum. For example, states could initially pay fee-for-service plus a prospective care management fee based on a practice's target changes, patient volume, the acuity of the patient mix, and infrastructure and process expectations. While this model would still be based on fee-for-service and might reward quantity rather than quality, it could provide the upfront funding that practices need to begin transitioning to new payment models.

For practices that achieved process expectations, Medicaid programs could test prospective payments that were risk-adjusted and reflected patient volume and performance; the percentage of prospective payment could increase over time as performance optimized.[78,79] Payments could also reward quality outcomes, cost reductions, and patient experience. This mechanism would support holistic team-based care while also recognizing non-visit-based work such as phone calls and e-mails. However, such quality-based incentives would have to be large enough to counteract concerns about underutilization.[80] Ultimately the payment model, like the practice supports, should recognize different levels of physician engagement in practice transformation and apply a "no wrong door" approach to change.

Medicaid could "go it alone" but might do better in engaging with multiple payers. As a significant insurer in many state markets, Medicaid has sufficient influence to drive care redesign through payment policies, particularly in practices with a high volume of Medicaid patients. With an additional 20 million beneficiaries expected between 2014 and 2019, Medicaid could exert this influence to support a sustainable infrastructure for the expanded population.

Interviewees noted, however, that a single community strategy funded by multiple payers might more effectively sustain practice transformation, given Medicaid's historically low provider rates. Thus, joining with other payers may be necessary to assure sufficient investment in practice modernization across a majority of a state's primary care providers. In that spirit, CMS recently announced sites for the Multipayer Advanced Primary Care Practice demonstration, which would allow Medicaid to join with Medicare and private insurers in state-based reform efforts to improve primary care delivery.[81] Meanwhile, many Medicaid programs are launching environmental assessments of practices to understand which high-volume Medicaid practices may qualify for the Medicaid EHR incentive program funded under the American Recovery and Reinvestment Act of 2009. States could exploit these findings to feed their practice transformation strategies.

POLICY CONSIDERATIONS
Several vehicles created by the Affordable Care Act could help states maintain primary care capacity while cultivating distinct aspects of practice transformation (Exhibit 3). However, support for primary care providers would be greater if states used these provisions in a strategic and coordinated way and if the U.S. Department of Health and Human Services developed grant applications that covered multiple provisions. While many of the provisions, such as health homes and increased rates for primary care providers, have limited time periods, states should consider how to leverage their short-term use for longer-term benefit.

Exhibit 3. Affordable Care Act Provisions That Support Practice Transformation

Provision	Description
Section 2703. State Medicaid option to provide health homes for enrollees with chronic conditions	A state may receive 90 percent FMAP for two years if it provides medical homes for adults with multiple chronic conditions or serious mental illnesses. CMS will allow states to spend up to $500,000 of Title XIX funding for planning purposes. Health homes must include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referrals to community and social supports, and HIT.
Section 3021. Establishment of a Center for Medicare and Medicaid Innovation (CMMI) within CMS	As its name implies, the CMMI's mission is to research, develop, test, and expand innovations, including those that address primary care practice and payment reform. States can use CMMI funding to develop innovative physician and physician network models for delivering and financing shared practice supports.
Section 3502. Establishment of community health teams to support the patient-centered medical home	Once funding is appropriated, CMS will establish a grant program for states to develop community health teams for persons with chronic conditions. The focus will be on increasing access to comprehensive, community-based, coordinated care.
Section 5405. Primary Care Extension Program	The Agency for Healthcare Research and Quality (AHRQ) received authorization of $240 million to provide grants to states and localities until 2014 to support primary care providers in prevention, health promotion, chronic disease management, and mental and behavioral health services. Grants will be used to develop state-level primary care extension hubs (which must include Medicaid) and to fund local health care extension agents, who will help primary care practices implement quality improvement or system/practice redesign.[82] AHRQ recently announced a $1.5 million grant opportunity for up to three entities to assist leading state-level primary care practice support efforts that could later become models for a national primary care extension service.
Section 1202. Payments to Primary Care Physicians (part of Health Care and Education Reconciliation Act)	Payments for primary care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) will be increased to 100 percent of Medicare payment rates for 2013 and 2014. States will receive 100 percent federal funding for the differences between Medicaid and Medicare payment rates. Primary care services include evaluation and management services, as well as those related to the immunization administration and toxoids for specific Current Procedural Terminology codes.

A CMS review of current policies and regulations beyond the Affordable Care Act could identify additional opportunities to assist states' development of shared support models. For example, CMS could:

1. Reevaluate the Medicaid EQRO regulations to allow enhanced federal funding for efforts, such as leadership training, practice management, and practice coaching, related to quality improvement.

2. Allow states to directly hire qualified practice coaches as skilled medical professionals and receive an enhanced FMAP of 75 percent.

3. Allow states to use the enhanced 90/10 federal match for planning and implementing the Medicaid incentive program that addresses shared practice supports to enable the meaningful use of EHRs.

4. Reevaluate CMS regulations that limit states' abilities to offer large incentives to providers through their managed care programs.[83]

5. Reevaluate managed care regulations requiring that incentive payments to physicians be paid by the MCOs and not by the state. Given that such payments are more powerful when aggregated, some states with managed care programs prefer to pay providers directly; current regulations, however, prohibit this.

6. Expand the Multipayer Advanced Primary Care Practice demonstration to include a larger number of sites and to facilitate rapid exchange of information among them—as well as among other innovative programs that are not part of the current demonstration.

7. Disseminate the experiences of programs that support the development of shared resources for small practices serving large numbers of low-income and minority patients. This is critical to ensuring that the lessons learned are not lost in discussions about practice transformation and medical homes.

CONCLUSION

As states prepare for a historic Medicaid coverage expansion—the addition of another 16 million to 20 million additional Americans—they must innovate now or risk a shortage of necessary primary care services for current and future beneficiaries. State Medicaid agencies in particular could drive primary care redesign by providing shared practice supports to small practices, particularly those serving large numbers of Medicaid patients. At the same time, CMS could revise existing regulations and write Affordable Care Act regulations with an eye toward supporting states and primary care practices in the new paradigm of creative staffing, advanced technology, and adaptive payment. States should especially look to early innovative programs for models applicable to the purchase of high-value primary care, provision of shared resources, and establishment of virtual networks of practices. As a result, Medicaid will likely be able to show that these models can increase physician and patient satisfaction, achieve better-quality outcomes, and increase efficiency.

APPENDIX A. EXPERTS AND KEY INFORMANTS

Federal officials
David Meyers, M.D., Agency for Healthcare Research and Quality

Health plans
David Share, M.D., M.P.H., Blue Cross Blue Shield of Michigan
David Labby, M.D., Ph.D., CareOregon
Winston Wong, M.D., M.S., Kaiser Permanente
Kelly Pfeifer, M.D., San Francisco Health Plan

Improvement organizations/consultants
Sheldon Horowitz, M.D., Improving Performance in Practice
Sarah Shih, M.P.H., New York Primary Care Information Project
Jonathan Sugarman, M.D., M.P.H., Qualis Health

Professional societies and boards
Michael Barr, M.D., M.B.A., F.A.C.P., American College of Physicians
Larry Hammer, M.D., American Academy of Pediatrics
Elissa Maas, M.P.H., CMA Foundation
Rosemarie Sweeney, M.P.A., American Academy of Family Physicians

Providers
Richard Baron, M.D., Greenhouse Internists, and previous past chair of American Board
    of Internal Medicine
Allen Dobson, M.D., Cabarrus Family Medicine, and former head of Community Care of
    North Carolina

Researchers
Tom Bodenheimer, M.D., University of California, San Francisco
Kevin Grumbach, M.D., University of California, San Francisco
Leif Solberg, M.D., Health Partners Research Foundation

State Medicaid officials
David Kelley, M.D., Pennsylvania Department of Public Welfare
Foster Gesten, M.D., New York Department of Health
Bill Golden, M.D., Arkansas Medicaid
Lynn Mitchell, M.D., M.P.H., Oklahoma Health Care Authority

Other health care leaders
Sophia Chang, M.D., M.P.H., California HealthCare Foundation
Harold Miller, M.S., Network for Regional Health Improvement and Center for Health
    Care Quality and Payment Reform
Dennis Weaver, M.D., EastPoint Health
Lyndee Knox, Ph.D., LA Net

APPENDIX B. CHANGE CAPACITY AND LEADERSHIP ASSESSMENT TOOLS

Organization/ professional society	Assessment tool	Web resource
American College of Physicians (ACP)	The ACP Medical Home Builder provides affordable and accessible online guidance and resources for practices involved in incremental quality improvement changes or significant transformation of their practices. This online tool helps practices: (a) quickly assess seven key areas; (b) identify specific tools and resources based on responses to a "practice biopsy"; and (c) prepare for recognition as a medical home.	http://www.acponline.org/running_practice/pcmh/help.htm
HealthTeamWorks	HealthTeamWorks, formerly known as the Colorado Clinical Guidelines Collaborative, is a nonprofit multistakeholder collaborative. It is using evidence-based medicine and innovative techniques to redesign health care delivery systems and promote integrated communities of care. Participating practices in the collaborative are assigned a quality improvement coach who helps them complete assessments that identify their strengths and needs and determine areas of focus.	http://www.healthteamworks.org
Improving Performance in Practice (IPIP)	The IPIP initiative conducts assessments to determine a practice's capacity for quality improvement work. Given IPIP's focus on health information technology, the initiative assesses whether a practice would be willing to use a registry to manage its populations (if it doesn't already) or be able to extract process and outcome data from existing electronic medical records.	http://www.ipipprogram.org/
Institute for Healthcare Improvement (IHI)	IHI's Primary Care Practice Coach is a 12-month virtual development program that incorporates an assessment of the practice context. Assessment topics include "the quality of the leadership vision and execution strategy" and "the human dynamics of change." These areas: a) identify changes in leadership interaction and behavior needed to achieve specific outcomes; and b) identify the elements of a well-chartered improvement team. The Coach also identifies individual and systemic reactions to change and assesses the adaptive reserve in the organization, team, and individuals.	http://www.ihi.org/IHI/Programs/ProfessionalDevelopment/PrimaryCarePracticeCoach.htm?TabId=1/

Qualis Health	As a product of its Safety Net Medical Home initiative, Qualis Health developed the Patient-Centered Medical Home Assessment (PCMH-A) to help systems and provider practices move toward the "state of the art" in delivering patient-centered care in the context of a medical home. Upon completion of the PCMH-A, providers receive a score, on a scale of 1 to 12, indicating the practice's progress toward achieving patient-centered care. The results can be used to help providers identify areas for improvement.	http://www.qhmedicalhome.org/safety-net/publications.cfm#products
Reducing Disparities at the Practice Site (RDPS), Michigan	The RDPS initiative uses three tools with participating providers to identify practice leadership and change capacity: (1) a cultural assessment form for use with physicians, practice administrators, mid-level providers, and registered nurses; (2) a cultural assessment form tailored for use with medical assistants, billers, receptionists, and other staff; and (3) a practice assessment instrument that captures all other practice information with the exception of medical record review. Following these assessments, the project team develops a tailored work plan to help identify gaps, as well as opportunities for practice improvement.	Not available online.
TransforMED	TransforMED (a subsidiary of the American Academy of Family Physicians) has practice-assessment tools, based on questions to identify leadership and change management capacities, that help to pinpoint resources needed for a practice to implement the PCMH model. By gathering information from the entire practice about change management, communication, leadership, teamwork, and job satisfaction, the assessment measures a practice's readiness to implement change.	Baseline Practice Assessment: http://www.transformed.com/assessment-baseline.cfm Change Readiness Survey: http://www.transformed.com/assessment-change.cfm Medical Home Implementation Quotient (MHIQ): http://www.transformed.com/MHIQ/aboutMHIQ.cfm Medical Home Vitals: http://www.transformed.com/Vitals/index.cfm

APPENDIX C. LEADERSHIP DEVELOPMENT RESOURCES

Organization/ professional society	Leadership development activities	Web resource
American Academy of Family Physicians (AAFP)	Offers a curriculum guideline to assist residency program faculty in leadership training. Supports various national leadership workshops to help physicians, residents, and medical students who are pursuing careers in family medicine to develop their leadership skills.	http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/rap/curriculum/leadership.Par.0001.File.tmp/Reprint292.pdf http://www.stfm.org/leadership/leadershipuser.html
American College of Physicians (ACP)	The Leadership Enhancement and Development (LEAD) program targets internists early in their careers. It offers a variety of activities designed to give participants the skills, resources, and experiences needed to become effective leaders.	http://www.acponline.org/education_recertification/resources/leadership_development/
California HealthCare Foundation (CHCF)	The CHCF Health Care Leadership Program equips medical professionals with the skills they need to influence health care policy and delivery in California.	http://www.chcf.org/media/press-releases/2009/california-healthcare-foundation-announces-fellows-for-health-care-leadership-program
Institute for Healthcare Improvement (IHI)	Offers Web-based educational resources (such as articles) and interactive tools (e.g., an Executive Review of Improvement Projects tool) to help train providers in leadership skills that could help drive system improvement. IHI recently launched the IMPACT Leadership Community, a collaborative series that convenes providers from a diverse set of health systems. These individuals work with each other and with IHI experts to gain skills in implementing key leadership processes needed to improve care.	http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/ http://www.ihi.org/IHI/Programs/IMPACTLeadership/
Qualis Health	This health care quality improvement organization is currently developing "engaged leadership resources," such as educational webinars, for providers participating in the Safety Net Medical Home initiative.	http://www.qhmedicalhome.org/safety-net/engagedleadership.cfm
Residency Review Committee for Family Medicine	In 2007, the Committee required that family medicine residency programs incorporate leadership training into their curricula.	http://www.acgme.org/acWebsite/downloads/RRC_progReq/120pr07012007.pdf
TransforMED	TransforMED is beginning to provide educational "tips" briefs online to help physicians better understand leadership and change management concepts.	http://www.transformed.com/workingpapers/LeadershipTipsPhysicians.pdf http://www.transformed.com/workingpapers/8Tips-changeManagement.pdf

On-site leadership development resources		
Blue Cross Blue Shield of Michigan (BCBSM)	BCBSM's Provider Group Incentive Program gives practices access to change management facilitators who use practice transformation methods derived from the Lean for Clinical Redesign Collaborative Quality Initiative.	http://www.michiganpcc.org/MIPCC/Files/crisis_part2_web.pdf
Group Health Physicians	Group Health's Practice Leadership and Development programs offer practices' staff on-site workshops and training in new clinical acculturation, leadership development, and patient–physician communication.	http://www.ghpmd.org/Careers/PracticeLeadershipDevelopment/tabid/113/Default.aspx

APPENDIX D. FINANCIAL MANAGEMENT AND ADMINISTRATIVE RESOURCES

Organization/ professional society	Resources and assessment tools	Web resource
American College of Physicians—Center for Practice Improvement and Innovation	Financial management tools Payment/coding tools	http://www.acponline.org/running_practice/practice_management/financial_management/ http://www.acponline.org/running_practice/practice_management/payment_coding/
American Medical Association	Practice Management Center Solutions for Managing Your Practice	http://www.ama-assn.org/ama/pub/advocacy/centers-engaged-advocacy/practice-management-center.shtml http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice.shtml http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/practice-management-tips.shtml
California HealthCare Foundation	Small Practice eDesign Model Toolset for Aggregators Implementing the CHCF Small Practice eDesign Model Practice management systems for safety-net clinics and small group offices Improving Efficiency in the Safety Net: Management Engineering Practice and Cases	http://www.chcf.org/projects/2009/small-practice-edesign http://www.chcf.org/publications/2010/05/toolset-for-aggregators-implementing-the-chcf-small-practice-edesign-model http://www.chcf.org/publications/2009/02/practice-management-systems-for-safetynet-clinics-and-small-group-offices-a-primer http://www.chcf.org/publications/2007/12/improving-efficiency-management-engineering-comes-to-the-safety-net
Primary Care Information Project	Improve Your Practice's Quality of Care	http://www.nyc.gov/html/doh/html/pcip/improve-quality.shtml
TransforMED	Practice management resources Financial Assessment Revenue Opportunity Tool	http://www.transformed.com/resources/Practice_Management.cfm http://www.transformed.com/assessment-financial.cfm

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