

A BEAUTIFUL DAY IN THE NEIGHBORHOOD — WON'T YOU BE MY NEIGHBOR?

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We dream of a beautiful day in the neighborhood ... when reimbursement covers much-needed between-visit care ... when all health information is available when needed and accessible to everyone sharing care for a patient ... when a system is structured to absorb the impact of addressing care needs for all ... when providing care that prevents chronic disease and poor clinical outcomes is rewarded instead of thwarted ... when all parties involved, including the patient and family, can be engaged and on the same page.

Can we go there together? Will you be my “neighbor”?

The Patient Centered Medical Home with its footing firmly planted on the tenets of both the primary care and chronic care models, has its lifeblood in a larger landscape — a fully integrated and functioning medical neighborhood. With its original framework

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based on observations posed in Wagner’s “It Takes a Region,” the medical neighborhood involves a larger systems-level view of the medical home model that characterizes the relationships and external structures necessary for the PCMH to be sustainable at the practice level.

“Too often we are so busy that patients need to coordinate their own care, which can lead to significant communication and follow up issues. The medical neighborhood includes ‘anyone that touches the patient’ – specialists, mental health providers, hospitals, home health providers, case managers, pharmacists, other community resources, and family members – all working in an integrated, coordinated fashion, to help ensure patients get the care they need when they’re sick, but even more importantly, helping them stay healthy,” comments Marjie Harbrecht, MD, executive/medical director for the Colorado Clinical Guidelines Collaborative. “Some communities use agreements or “compacts” to outline what information is helpful to

provide when patients go from one place to another. This has helped reduce confusion and redundancy and patients are much happier with the process.”

In the midst of what seems like rapid mobilization and alignment for practice transformation and health care reform in our state, there is an important player that needs to stay at the center of the medical home and the medical neighborhood – that is the patient. Eileen Forlenza, director of the Colorado Medical Home Initiative housed at the Colorado Department of Public Health and Environment comments,

“The key to PCMH is acknowledging the patient is a necessary participant on the health care team. Health and health care are a personal experience for the patient, and unfortunately that experience is often lost in the delivery process of those health care services. Elevating the patient’s role in the

delivery of health care by placing the patient in the center of their care, while promoting a healthy balance between personal responsibility and a coordinated health care team can promote healthier outcomes for everyone. That is the benefit of PCMH and why it is leading change in the approach to delivering quality health care.”

Recognizing that there are plenty of barriers interfering with broad-scale PCMH implementation including a need for more resources or even just information, the Colorado Medical Society and the state chapters of the primary care societies are working together to reach primary and non-primary care practices to support adoption of the Patient Centered Medical Home.

“The Systems of Care grant brings all the specialties together for a conversation within the family for the purpose of breaking down care silos and improving care,” says Chet Seward, senior director of health care policy at CMS. Born in the minds of CAFP leaders, the project, funded by the Colorado Health Foundation, will support the process of gathering statewide physician feedback on challenges for implementing the PCMH

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and use physician and consumer input to help develop a meaningful strategy for approach and development of resources — for both physicians and consumers.

A statewide poll surveying both primary care and specialist physicians for opinions concerning the Patient Centered Medical Home and coordination of care will be made available by Colorado Medical Society in September. The project will also feature the hosting of focus groups, two summits and the use of resource advisors. The resource advisors, trained by CCGC, will have the role of reaching out to practices for educational and initial technical assistance in practice transformation work toward becoming Patient Centered Medical Homes.

This is an exciting time in Colorado with significant state-level momentum building around many initiatives such as the governor's Center for Improving Value in Health Care, Health Care Policy and Financing's Accountable Care Collaboratives, and Health Information Exchange through the Colorado Regional Health Information Organization—all of which will support the work that our primary care practices are doing to transform their practices and communities into medical homes as part of integrated medical neighborhoods.

There is lot of work before us in order to realize these ends but what a victory it will be to be able to someday say, "It's a beautiful day in the neighborhood. It's great to have you as my neighbor!"

Medical Home Pilots/ Initiatives in the State of Colorado

- Colorado Medical Home Initiative—CDPHE, CCHAP
- Multi-State, Multi-Stakeholder Demonstration Pilot—CCGC
- Family Medicine Residency PCMH Project—CCGC, UCD, CAFMR, CIFM
- Safety Net Multi-State Medical Home Initiative—CCHN

¹Center for Studying Health System Change. (2008). Building medical homes on a solid primary care foundation. Policy Perspective: Insights into Health Policy Issues, 1, 2-8.

²Wagner, E. et al. (2006). It takes a region: Creating a framework to improve chronic disease care. The McColl Institute for Healthcare Innovation/The California HealthCare Foundation. pp 1-31.