A Regional Medical Home Co-Op (and ACO?)

An Innovative Support Infrastructure for Healthcare Reform

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Many critics are now saying that Congress should be concentrating more on how to improve the way healthcare is organized and delivered, not just on how to finance expanded coverage. To their credit, congressional leaders have embraced innovation and modernization as a means of creating more cost effective delivery of healthcare. Six key care delivery innovations addressed in the House Tri-Committee Bill are: electronic health records, evidence-based medicine, telemedicine, bundled services, medical homes, and accountable care organizations. The medical home easily synthesizes the first three and could become the basis for a regional ACO health plan by incorporating co-op managed cost containment processes and benchmarks for reimbursement. In fact, this article will argue that rather than designing top-down solutions, the Federal government should promote and invest in a variety of local and regional innovations, particularly those built upon a solid communications infrastructure. A regional medical home co-op is the logical foundation upon which to build such innovation and modernization, and it is possible right now with the right kind of coordinated Federal support.

Ideally, a local Regional Health Information Organization (RHIO) would take the lead in organizing the necessary stakeholder alliances to form a non-profit cooperative with which government could contract for this infrastructure development. In many regions where there is no formal RHIO, there already exist consortiums and cooperatives that help health care providers benefit from bulk purchasing, shared services, and other business solutions (see the National Cooperative of Health Networks Association -- www.nhcn.org -- for examples). When partnering with RHIOs and other regional health care alliances, these rapidly expanding co-ops can provide an excellent platform upon which to build a dynamic regional communications infrastructure so essential for supporting care delivery innovation.

Initial Co-Op Formation. RHIOs or other regional alliances should be provided incentives to help organize the co-op if one does not already exist, and/or to support this new role for currently existing co-ops. The co-op then identifies resources and gaps in two domains, communications infrastructure and area health provider resources. A comprehensive development plan for the region is submitted to a lead Federal agency, probably HRSA, ideally for a single composite grant via a special Federal waiver rather than individual grants from many different agencies. The co-op completes the infrastructure development with consolidated Federal funding through HRSA.

The Communications Infrastructure. The key to the success of the co-op is a sophisticated regional communications hub, supported by the latest in smart technology. The non-profit co-op is modeled after the Community Health Network (CHN) in Tennessee -- www.communityhealth.net -- which is building a system that will maximize connectivity between patient and primary care physician (PCP) using a composite of best practices in telephonic case management. The model supports all six of the Congressional interest areas, especially the medical home, and improves communication (coordination) between the PCP and other providers, albeit not necessarily at an EHR interoperable level. One of the key advantages of the regional communications hub described here is that it enables physicians to outsource certain Medical Home patient support functions when necessary, using a comprehensive integrated call center network. This is particularly helpful for the small physician practice which cannot bear the expense of hiring a social worker, added phone staff, etc. A strategic mix of remote monitoring technologies and advanced call center algorithms enable the PCP to supplement face to face patient contacts with other indirect but effective communications methods, including telephone and Internet. The PCP directs the activities of the various call center staff specialists through a dynamic care plan template. The care plan is “dynamic” because it is enhanced with evidence-based medicine (EBM), applied technologies such as portable telemedicine, and community resources recommended to the PCP by the co-op. By outsourcing, PCPs can provide better care, to more patients, for less cost.

A mobile nurse technician in a mini-van serves as an extension of the advanced call center network and operates as the eyes and ears of the PCP, particularly for patients who are elderly, chronically ill, or otherwise at risk. The nurse technician is stationed full time in a zone, usually a zip code, and equipped with portable telemedicine equipment to capture vital signs and provide video capabilities, either one-way, two-way, or via “store & forward” (S&F) data collection servers, with data downloadable by the PCP and others approved for access**.** The mobile tech performs non-emergent and non-custodial mini-visits to gather information on the safety and well being of patients in accordance with their care plan and delivers it back to the PCP. This kind of zone-based mobile tech is projected to be cost effective due to the large number of prospective customers per square mile, including patients on Medicaid (the North Carolina model) and those supported by Home and Community Based Care, e.g., via a Medicaid waiver. Besides serving the home patient, the mobile techs and the call center in tandem can contract their services to nursing homes, assisted living centers, employers, schools without nurses, etc. Other potential contract functions include home delivery of prescription medications, transport of patients to nearby bus or train stops for Medicaid or ADA reimbursement, and pandemic or bio-terror response missions.

Virtual House Calls & Mobile Clinic Visits. Exploratory discussions are underway between CHN /Access Technologies, U.S. and large mobile clinic operators to consider a logical interface between the mobile tech and larger mobile clinics. The latter require that providers participate real time from remote locations, emphasizing primary care and some specialty care, while mobile techs primarily emphasize disease management and monitoring of the care and well being of elderly or other at risk patients. The mobile tech’s telemedicine data is typically not reviewed by PCPs or others real time but relayed via S&F. Mobile-techs are also well positioned to provide patient transportation to and from the mobile clinics if needed.

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Telephonic Case Management. The science of telephonic case management has advanced considerably in the past decade, particularly with increased research and testing of models that benefit from EBM-generated algorithms. Advanced call center models are being developed in clinical settings to address the full array of patient needs. These include call centers for disease management, primary care triaging, post discharge monitoring to prevent readmissions, psychosocial and IADL support, coordinated patient transportation, and in-home electronic monitoring such as fall detectors, pill box and motion pattern monitors, etc.

The Medical Home Co-op will provide or procure the various specialized call center functions and link them to the PCP's care plan for each patient. The care plan is enhanced by the co-op's suggestions to the PCP regarding the scheduling of calls and the questions to be asked. Ultimately, however, the PCP makes the final decision regarding the care plan and patient communications strategies. The strength of the proposed Regional Medical Home Co-op is its ability to support and extend the capabilities of PCPs through enhanced connectivity, a dynamic care plan, advanced call center technologies, and a mobile nurse technician . The call center and mobile tech tandem are also inherently scalable, phased in one zip-code at a time if necessary. The result is reduced start up costs and a more immediate return on investment.

The Co-Op Health Plan. The Regional Medical Home Co-op could even evolve into a safety-net health plan that could double as a "benchmark" rate setting mechanism for all public and private health plans. This kind of co-op health plan would offer a fair and equitable alternative to the controversial public plan now being debated in Congress and would mitigate the private insurer's perception of an uneven playing field between public and private fee structures by creating a provider sponsored HMO health plan. The regional co-op provider members (hospitals, physician groups, and other providers) could enter the realm of payer, but with the following kinds of limits and conditions:

(1) Re-invest 10% of the plan's "profits" (surplus), primarily in enhancements to the communications hub;
(2) Offer commercial health plans and their provider networks access to innovations and cost efficiencies generated by the co-op's communications infrastructure;.
(3) Provide a primary care safety net program, including call center triaging, by combining FQHC resources with those of the co-op, i.e., telephonic case management and mobile-tech supports, available at cost to all health plans;
(4) Recognize Health Service Regions defined by RHIO boundaries and/or Medicare Hospital Referral Zones; and
(5) For its own patient members have the option to contract for administrative services, claims processing, premiums, etc., through its state Medicaid program or Medicare.

The concept of a Regional Medical Home Co-Op is possible right now with the right blend of Federal incentives and simplified grantmaking. Even if a co-op chose not to become an ACO, the infrastructure allows PCPs to increase their reach significantly in both scale and geography to deliver better care at lower cost. Isn't that what we want from health care reform?

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Retail Clinics Challenge the Concept *....continued*

Even a simple condition can quickly get complex for these patients, so they require a medical home that is staffed with physicians and specialist providers, offers advanced care, and has sophisticated laboratory facilities to provide comprehensive care that is both preventive and acute. Medical homes are important, but retail clinics have challenged whether an entirely physician-controlled care delivery system works. Certainly, a true medical home is needed for the chronically unwell, and those with complex ongoing health care conditions such as diabetes and cancer, but increasingly, the healthier population wishes to manage their own health. This means having choices about care delivery, including a spectrum of options from self-care to professional medical attention. Informed consumers are comfortable having multiple medical homes to suit different needs, and managing their own health information.

WHAT ARE RETAIL CLINICS?

Retail clinics are small, limited-service medical clinics located inside grocery stores, pharmacies, and other retail locations. A limited menu of basic medical services is delivered in a consumer-friendly environment by appropriately trained mid-level practitioners rather than physicians. Most retail clinics accept cash, credit cards, and insurance as payment, with moderate pricing and primarily walk-in visits that typically last less than fifteen minutes.

As medical homes are redefined and new relationships are created between patients and caregivers, traditional medical homes led by physicians will need to incorporate other forms of medical service into their model of care. This includes retail clinics, self-care, and other wellness professionals such as chiropractors, acupuncturists, and physical therapists. The core of the medical home should be comprehensive medical care that is coupled with information that empowers the consumer, rather than a controlling, paternalistic approach that requires a dependent patient.

TWO MODELS FOR RETAIL CLINICS

Retailer-owned clinics include Walgreens, CVS, and Krogers (with their respective clinics). Retailers use clinics to extend their brand offering in the health and wellness category, as well as to augment their service offering with one-stop convenient shopping. Retail clinics give consumers another reason to stop in a store – and buy other items while they're there. They are, in essence, an expansion of what we expect from the conventional retail experience rather than an extension of the healthcare delivery system.

Hospital-owned clinics are a different story. Hospital systems use retail clinics to extend their services and extend into new communities – they actually serve to keep the patient within their medical home by expanding the delivery system into new, more convenient settings. They remind the patient of their commitment to wellness and ensure their facilities and physicians are "top of mind."

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