RICHARD LORD, MD: What I want to do, and Mark Andrews asked me to think about this, is around Patient-Centered Medical Home. And I don't-- how many folks in here are in a practice, an outpatient practice of some sort? I know some folks are doing nursing home care. OK. How many of you who are doing that are in medical homes that are designated by NCQA? OK. So, it just helps me with that.

The Patient-Centered Medical Home movement in North Carolina is alive and well. Just for you to be aware, we're leading-- we're in the top three states in the country with practices and physicians who are recognized. To give you an example, last year in North Carolina, I think we were about 1,500 physicians who were in-- 1,500 physicians who were in practices NCQA-designated medical home. In Kentucky, they had nine.

We are moving, and there are payment systems and other things in the state that are happening that are going to move this, I think, going to continue to move this across the state. One of the reasons I'm here talking this morning is at least at Wake Forest, we are working with all 23 of our community physician practices, all the academic primary care practices, to get us all recognized as NCQA medical homes.

So what does that mean? We all have certifications and that sort of stuff. But let me talk about why I think this is important. And first, I have no disclosures of interest. I wish I did sometimes, but I have nothing to disclose.

So what's a medical home? What's it defined as? This is just one of the definitions that the AAP, the ACP, AAFP-- bunch of groups have agreed to.

It's an approach to providing comprehensive primary care for children, youth, and adults. The Patient-Centered Medical Home is a health care setting that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patient's family.

So again, this idea of partnerships. And when we start looking at all the other things we've heard about up to this point, I think we can see where partnerships are important. Well, it's a way of providing services.

I just try to-- I'm more pictorials, probably my economics and graphs and that sort of stuff. But when we look at this and take a look, this is sort of our health system if we don't have and what I think had been going on for years before the medical home model. It was a little bit different in managed care. But in the 2000s, I think this was it.

We had the patient. We might have a primary care physician that's out there. The patient may interact with their primary care physician.

They might interact with a health care system. And so, they might choose to go get some hospital care, or go to the emergency room and they're admitted. And then they come back. And then they might go and get some health education. Or maybe they go to physical therapy or a medical specialist.

But our health systems were over here. And at Wake, you could throw the primary care in that group as well. It was really a one-way designation. The patient had to figure out what it was they needed.

And oftentimes, I mean, I'm not very good-- when I have a legal issue, fortunately, i don't have many. But when I do, I want a lawyer to try to help me. I don't figure that out on my own.

The same thing, I think many times folks need this sort of guidance of a physician. Another way of providing services is we might bring the patient into a health system. We're going to bring them in there, and then we're all kind of reaching in those arrows. Everybody were throwing everything at this.

And we started doing this a little bit at Wake. And what-- if you talk with Pam Duncan, who's kind of leading all of our transitions of care-- all those programs, what we started recognizing is that you can over-resource people, if that makes sense.

You've got a patient, and so now you've got all these things going in. And they're like, oh my gosh, I'm overwhelmed. I'm getting no bene-- I'm stressed out because there's people at my door every day. And I can't get rest, and people are calling me.

And as Franklin was saying, somebody may get a little bit-- well is it two pounds or three pounds? Do I need to go up on insulin? That sort of stuff. So, that's another way that can happen.

Really what the medical home model is trying to get at is this-- is that you need a primary care provider slash team working with a patient. So it's really getting those patients identified with a primary care physician, and then you get interaction going both ways.

You've got the patient and the physician kind of coming together, the primary care team coming together. And then trying to help the individual realize, well, maybe they need some Hospice at this point. Maybe that's not. Maybe they're going to need some social services. And so there's some interaction going both ways where if I need something, I can reach out and I know that those services are there.

And I can tell you right now at Wake we're working on this model. There are other models. We're partnering with Cornerstone Health. Some of you may be involved with Cornerstone.

But they actually have these things called hubs. So they're in this model, so they get all of their patients. If you're going to be a patient at Cornerstone, you get a primary care team assigned to you. And that team has many different facets to it.

It may have-- usually you've got a primary care physician. You may have an advanced practitioner with that. You may have a care navigator. You may have a patient care advocate involved in that. But they also have hubs.

So for their primary care physicians, if I've got a patient that needs a social work need, they may not have been in the hospital. So they haven't gotten to readmission issue, but they have a social work need. They have a social work hub where their primary care physicians can call the social worker and get them involved.

Maybe they have a medicine need. With all these folks, we're hearing about getting people off medicines. They're on 20 meds. I need a pharmd to take a look at that. They have a pharmd hub that you can reach out to and get some assistance with actually working with that patient around that.

So they have health education. They have mental health specialists. So these hubs that happen around this. And this, I think, is going to be an important model where we're moving around this to try to create this patient primary care team collaborative within looking at all these different services that go on.

And that's certainly, from what Pam Duncan talks about at Wake and talks to me incessantly about, is sort of the reality of that, you can have all these services, but unless you develop a trusted relationship with a health professional, it will be all for naught.

Because the patients don't understand depending on what they may not trust you with what you're saying. Well, we're not going to put you in the hospital. You just don't want to put her in the hospital because you all are going to get penalized.

Well, no, maybe that's not the right place at the right time. We're hearing about the right care. There needs to be somebody that's trusted in that.

This model, this primary care model, or the Patient-Centered Medical Home model, what it can do is help us get those patients and understand what the right care is at the right time.

Now the difficult piece where this model needs all the other services we were hearing about before, is that there will be patients that get so complex that they overwhelm me as a primary care physician when I'm trying to take care of 1,800 or 2,000 patients on a panel to try to do all this. That 1% that we hear about or we're seeing about these really high complex patients, I may not always be able to take care of them just in this model.

And they may transition into a pace model. They may transition into some other model. They'll still need to be that communication back and forth so we can work together.

Now, what are the studies of medical home showing? Well, right now in general, they've shown decreased ER utilization, decreased hospitalization, decreased per member, per month cost. That's in general that if we can get folks aligned.

Because if we go back and think about if we leave the patients in this model, where they're trying to figure out what they need yeah, and not to-- yeah. But I'll take Paul Grundy's attack with this. He's a big proponent of Patient-Centered Medical Home.

When we drive up and down the highways across the country and we've got emergency rooms-- not just here, they're all over the place with their billboard signs saying zero minutes for wait. And we have emergency rooms-- not just here, but across the country saying you can check in online.

OK, and I tell our residents that if you have time to sit down at a computer and check in online, it's probably not an emergency. It may be urgent. You may need to have something done because you don't want to miss work tomorrow. That sort of stuff.

But it probably doesn't need an emergency room. If you really have that time. That's the attack my mom would have taken with it. I can tell you, growing up and only going when there was blood or a bone sticking out, that's when we got to the emergency room.

But we can see how trying to create a collaborative around this and helping patients get into this type of model when we're trying to figure out, OK, when do I need-- when do I need to see a specialist? When am I going to need to see that? When do I need to talk with, and when do I need to hand off this patient into palliative care?

And try to have that conversation up front. Because I can tell you, one of the worst places to have this conversation is in the hospital. I try like the dickens, and I try to work with all of our residents to have them, particularly around anybody that seems to be failing but particularly with dementia-- we know the course of dementia, right? We're not going to cure that.

Why are we not having conversations way ahead of time as their primary care physician to say, what are your goals of care? And then figure out where these things begin to fit in within them.

Now, what did it show? I want to see, and it's interesting to say because we're in a geriatrics conference, what do we know about with the elderly? Well, group health-- the study-- one of the studies that was done, they're out in Seattle. And they are an insurance company and a provider, kind of like Kaiser.

And they have been at the forefront of primary-- of transitioning into this Patient-Centered Medical Home model. What they've looked at is that the patients like the experience better if you transition to a medical home, they felt that was a better experience for them. That's a plus in my mind.

If we've got somebody that's 80 years old and can get to my office, and they have a good experience having to interact with me, that's great. Better yet is if they don't even need to come to see me. That's really great. But when they do, if they can have a good experience.

They achieve better quality when they looked at the HEDIS measures, they were all going to be held to of are they getting the health care measures they need? Are they getting the care and the types of care they need? They did. And they did not see any increase cost by implementing this model.

And so it's been interesting looking at that. I didn't have time, and I didn't add this in last night. There was a study yesterday that was released in JAMA that's going-- you're going to see all kinds of, I think, press around it and a lot of commentary.

That one of the groups, they did a study looking at the Medical Home model and said there was no improvement at all in anything. And so people are going to have the dice this out. We've got three or four years of data saying that it does improve.

It decreases cost, improves quality, improves patient experience. And better yet, also along with doing all those things, which are the three most important things. The people that practice in a medical home, the staff, the providers are all happier.

Wow. How many of us can say that EPIC has made us happier? Yeah, or our electronic record has made us happier. For most of the things we're doing, we can't say that. This model does that. Within that.

And I think one of the ways that it helps us do that is that we create a team. When we think about all these other models that we just heard about, those of you-- if you, or any of you-- if you're seeing patients in an office, how many of you all would have time to answer a phone call from the PACE program about one of your patients?

To get a call from Franklin for a Care at Home patient, and then have a care navigator from, say, from the Care Plus model that needs to talk to you. And now you've got a social worker from some other home health agency. How many of you all have time while you're seeing patients to step out of the room and answer all those phone calls?

None of us do. I certainly don't, and I'm in academics where we have a little bit more time per patient. But we don't have time to do that.

Where these models-- what this model does is it begins to-- and you'll hear the term get people working at the top of their license-- but it brings a team around the patient to be able to field some of those things.

So, maybe-- and we're looking at Wake. How do we use advanced practice folks? So, nurse practitioner, physician assistants to help us with some of this.

How do we have embedded-- we have embedded at Wake right now. We have embedded with us a mental health counselor who can do substance abuse screening right there. If you screen positive out of two questions, he's in the room with you, talking with you, to do a full screen and then offering you counseling right there to move on.

That takes the burden off me. I can identify that, but I'm not then trying to say, well, let me talk with you. Let me see if I can get you maybe to drive across town to see somebody else in another office. And maybe you go, maybe you don't.

We're looking at bringing in psychiatry into our office. And that's a big thing we're looking at with co-locating. We already have psychologists. But there's a lot of mental health that's going on in primary care, that we're writing all kinds of prescriptions that we need help around that as well.

So as we develop these models of care, I think this is sort of the model that we're taking at Wake and kind of beginning to think about that we've looked at. Initially at Wake Forest, we started looking only at the top of this pyramid, the high utilizers. They get the full court press.

We'll throw everything at them to try to help, because that's what it takes. Because these are the folks that may not have resources. They've got seven disease entities. They may be on 15 medications. They need everything thrown at them.

But initially at Wake, before we started moving with the Medical Home model, we were doing nothing at the bottom of this pyramid. OK, we were not doing anything for coordinating care for everyone to make sure that all the patients.

They were getting their colon cancer screening. They were getting their mammography. They were getting the other preventative health things. They were getting their flu vaccines so they don't die of the flu. They were getting pneumococcal when they needed it.

We also were not doing a great job at looking at patients with chronic disease. They're getting their disease managed. Making sure-- we knew in our office only 22% of our diabetics were getting their eye exams. 22%-- not great.

We, since EPIC has come in and not been very helpful, our rate of screening for microalbumin has gone way down. Because we didn't have it set up right to help us identify those patients. We're coming out of that a little bit, but it impacted the quality of care.

So it's making sure that those folks are getting that. Then when you have the diabetic, I know none of y'all have diabetics that-- everybody's below eight, right? I mean, I've got diabetics.

Lady the other day came in was concerned that her hemoglobin A1c was 14.9. I thought, that's great. But she was like, I'm panicked. But I look back over the last three years of her A1cs. Guess where all of them were? 14.

Yeah, so I'm sort of like, well, we need to work on it, but it's not like it just got to 14 yesterday. Those folks then need some extra help within our practices to help them achieve goals. Motivational interviewing, health navigators, coaches coming up with innovative ways to help them along.

Because the problem is if we only focus at the high end, if that's all we do and we don't transform what we do at primary care, guess what happens? We just keep filling up the pipeline, right? Because we're not managing the folks at the lower end. We're not managing the folks with chronic disease.

So they get end stage renal disease, because we didn't figure out what was going on with their diabetes. Or we don't manage their CHF, so they keep coming in and out, and they get sicker and sicker. And so they just continue to fill up that top 1%. And we'll never make headways.

So I think it's a combination of all these things. We need the resources that have to take care of our sick, the sickest of the sick, and these other individuals that need our care. But we've got to have this medical home model as well.

So, right now the take home point, I think, for all of this is that we've got to have that all these other services, unless there's a trusted relationship there, it's very hard at times to get people into the home. As Franklin was alluding to, many of my patients will not allow somebody into the house.

If somebody is just doing a cold call, until I see them and say, I'm sending them to you, then they're a little more comfortable with that. Whatever reason-- I mean again, I guess I've been-- some of my patients-- I've been here now 14 years. Over that period, I've gotten to know them. They've trusted me.

They think I make reasonable decisions. And so they're-- that's happening for them. So, and so I think we've got to make sure that we create an environment around that.

I'm not going to go through all the impact-- all the ways that you have to go through to create the medical home. I just want to raise some awareness of the medical home model. It's out there. We are working on it at Wake.

I'm more than happy to talk to anybody at any time. CCNC, Community Care North Carolina, and the Northwest AHEC-- both of them are hugely interested in helping any of you who are not medical homes. They will bring people in for free to help you understand what it takes, to help you develop the medical home.

Many times they will pay the fee for you that you have to pay. We always have to pay somebody to give us recognition. But they will oftentimes pay that fee.

It can be a transformative endeavor for your practices to think about this. So, I would strongly encourage you if you have an interest. Talk with Northwest AHEC. Talk with CCNC if you're in an area where-- and you're involved with that network as well. They will be more than happy to help you with this, because they feel like it's a better way to do primary care. And I'm going to stop there.