



## ASHP Policy Analysis

# Pharmacists' MTM Services Key to Health Care Homes' Success

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A patient-centered, team-based primary care model that is being tested nationwide may be able to stitch together the fragmented health care system. Payers are expecting improved patient health and lower costs from the health care (medical) home model,<sup>1</sup> which uses a physician-led team of professionals to coordinate patient care. There are a myriad of ills this model is hoping to cure. The current system provides patients with fragmented, uncoordinated care by a dwindling number of primary care physicians who are paid significantly less than their specialized colleagues. Little attention is paid to preventive care, and patients generally are not involved in the care they receive. Meanwhile, health care costs are high and there are few financial incentives for providers to improve patients' health. All of these problems are perpetuated by the health care reimbursement system, which pays for discrete services to treat a patient's medical problems rather than paying for services to keep a patient well.

However, under the health care home model, patients are actively involved in their care and have greater access to health care providers, often being able to contact a health professional at any time of the day or night. Many of the health care homes being tested focus on patients with multiple chronic conditions because those patients have the greatest need for care coordination. To address the lack of reimbursement for care coordination services, the physician heading a health care home receives an additional fee and may also receive financial incentives for meeting quality indicators, depending on the program.

As physicians establish their health care homes, pharmacists have an opportunity to become involved by providing medication therapy management (MTM) services to patients, especially patients diagnosed with multiple chronic conditions. Those patients have a greater need for medication selection, dose adjustment, laboratory monitoring, drug-drug interaction identification, and patient medication counseling, all of which are also key requirements of a health care home. Pharmacists, the health professions' medication experts, are best able to manage chronic diseases by providing

those services.<sup>1</sup> Results of many studies have shown that pharmacist-provided MTM services improve patients' health and reduce health care costs.<sup>1-4</sup>

Pharmacists' value in the health care home is recognized by an independent congressional agency that advises Congress on Medicare issues. In its June 2008 *Report to the Congress: Reforming the Delivery System*, the Medicare Payment Advisory Commission stated that a Medicare medical home's responsibility for patient medication reviews should be coordinated with a pharmacist.<sup>5</sup>

## Model is Building Momentum

The health care home model is drawing increased interest among key stakeholders, including health insurers, the Centers for Medicare & Medicaid Services (CMS), employers, state health agencies, health care worker organizations, and others as a way to provide better and less expensive patient care. In addition, health care reform proposals have incorporated the initiative as a way to improve primary care. To gain a better understanding of how a health care home is organized and how pharmacists can contribute under

\* Editor's Note: A health care home is also referred to as a medical home in the health policy literature. For the purposes of this paper, we will use the term health care home unless the term medical home is used specifically.

# ASHP Policy Analysis

this model, we describe CMS's national demonstration project and several state- and privately-run programs. If these programs improve patients' health and reduce medical costs, health care homes may be adopted nationwide.

## Origins

This model was first envisioned more than 40 years ago by the American Academy of Pediatrics (AAP) as "a central location for archiving a child's medical record" and has evolved to coordinate all aspects of a patient's care.<sup>6</sup> Broadening the concept in March 2007 through a joint statement the American Academy of Family Physicians (AAFP), the American College of Physicians, the American Osteopathic Association, and the AAP specified that a medical home should provide "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care."<sup>6</sup> Health care quality and patient safety are key elements of a medical home, with a focus on evidence-based medicine and patient involvement in making medical decisions. Through a medical home, a patient's care is coordinated by a team led by the patient's physician. The team is responsible for ensuring that all of the patient's health care needs are met. Medical homes are intended to improve patients' access to health care through "open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff."<sup>6</sup>

Under a medical home's payment structure, the increased level of care is recognized by paying for patient care coordination services. Such payments include "separate fee-for-service payments for face-to-face patient visits," enabling physicians to receive some of the "savings from reduced hospitalizations associated with physician-guided care management in the office setting," and may extend to "additional payments for achieving measurable and continuous quality improvements."<sup>6</sup> The payment structure also should take into account the types of patients being cared for within a medical home, the medical home's health information technology needs, and patient communication needs.

## National Standards Established

While there are many types of health care homes providing patient-centered services in various ways, the National Committee for Quality Assurance (NCQA) has set a benchmark for how care should be provided in this setting, the Physician Practice Connections-Patient-Centered Medical Home

(PPC-PCMH) recognition program.<sup>7</sup> To receive recognition, a medical practice must meet nine standards, such as managing and coordinating patients' care, using electronic prescribing, and regularly measuring and improving the practice's performance.<sup>8</sup> Further, practices must meet at least five of 10 elements under these standards, such as developing written standards for patient access and communication and showing that they have been met, adopting and implementing evidence-based guidelines for three chronic conditions, and tracking patient referrals.<sup>7,8</sup> Practices can be awarded one of three levels of recognition based on whether the practice meets the elements under each standard and the practice's NCQA score. As of November 18, 2008, 12 practices were operating PPC-PCMH medical homes.<sup>9</sup>

## Incorporating the Model Into Health Care Reform

The health care home model could be adopted more broadly if it were incorporated into a national health care reform initiative, as is recommended in two proposals. U.S. Senator Max Baucus (D-Montana), chairman of the Senate Finance Committee, encourages "further testing and implementation of the medical home model" in his 2008 health care reform paper.<sup>10</sup> Baucus proposes reducing or eliminating patients' co-payments to encourage patient participation in a medical home. President Obama's health care reform proposal, released before the November 2008 election, supports using medical homes to coordinate patient care for "patients being treated for multiple health conditions."<sup>11</sup>

A health care reform proposal by The Commonwealth Fund Commission on a High Performance Health System encourages "the adoption of the medical home model to ensure better access, coordination, chronic care management, and disease prevention."<sup>12</sup> The proposal estimates that by doing so, national health expenditures could be reduced by \$175 billion from 2010 to 2020.

## Pharmacists' Essential Role

Pharmacists have an essential role to play in helping patients manage their medications. Medication management is especially important in health care homes that treat patients with multiple chronic conditions. A physician needs a pharmacist to ensure that patients' medications and medication doses are appropriate to their conditions and to prevent and manage adverse drug events.

## ASHP Policy Analysis

Pharmacists nationwide are already providing MTM services outside of health care homes. As hospital, clinic, and medical group practice employees, pharmacists incorporate MTM into their daily practice to prevent adverse drug events, divert primary care patients from emergency rooms, and avoid unnecessary hospital admissions. Pharmacists also have worked with physicians to monitor the results of medication therapy and modify patients' medication regimens as necessary.

Most states allow pharmacists to resolve medication-related problems after entering into collaborative drug therapy management (CDTM) agreements with physicians.<sup>13</sup> Under CDTM, pharmacists assume an important role by providing critical medication and health care management, as well as by improving the public's general access to health care providers.<sup>14</sup> In the few states that do not allow CDTM agreements, physicians and pharmacists collaborate on patient medication management under more informal arrangements. Physicians with existing pharmacist CDTM agreements or more informal pacts to manage patients' medications who are interested in establishing health care homes can easily incorporate pharmacists into the health care home model. A pharmacist can be incorporated into the model in one of three ways: by being hired as a physician practice employee, by being hired as a physician practice contractor, or by receiving a fee for MTM services performed in conjunction with prescription dispensing. Regardless of how a pharmacist's MTM services are incorporated into the model and reimbursed, medication regimen review is a specific service that pharmacists are well qualified to provide.

### Medication Regimen Reviews

When a patient joins a health care home, a pharmacist should review all of the patient's medications, including over-the-counter drugs and dietary supplements. In this face-to-face review, the pharmacist would check the appropriateness of a patient's medications and the medication dosage. Any pharmacist recommendations for discontinuing, adding, or reducing medications would be referred to the physician for review. After the physician makes the final decision on the pharmacist's recommendations, the pharmacist could then counsel the patient on the revised medication schedule. A pharmacist-provided medication review should be done at least once a year for all patients in a health care home. Patients also should be able to contact the health care home pharmacist with questions about their

medications by either telephone or e-mail throughout the year. In addition, the pharmacist should provide his or her medication expertise to the physician and other health care home staff as they work with patients to identify appropriate medication therapy alternatives.

### Health Systems' Role in Health Care Homes

Health systems, and the pharmacists they employ, also have an opportunity to participate in health care home programs. Geisinger Health Plan's Personal Health Navigator, which will be discussed later in the paper, is one example of how a health care home can be created within a health system. Health-system pharmacists' experience providing MTM services and their experience working closely with physicians, nurses, and other health professionals to improve patient care would allow them to easily assimilate into a health care home team.

### Testing the Programs

As mentioned previously, this paper describes several medical home programs. First, we review the CMS Medicare Medical Home Demonstration project, which will test this model nationwide. Second, we examine two state programs, Community Care of North Carolina and Louisiana's Patient-Centered Medical Home program. Third, we look at three private programs: Geisinger Health Plan's Personal Health Navigator, Bridges to Excellence Medical Home designation, and AAFP's TransforMED program. These programs show the range of government and private entities testing the health care home model. However, this paper is not intended to include all health care home programs nor is it necessarily representative of all of the approaches being tested.

### CMS Medicare Medical Home Demonstration Project

Section 204 of the Tax Relief and Health Care Act of 2006 required CMS to create a medical home demonstration project that would provide "targeted, accessible, continuous and coordinated, family-centered care to high-need populations."<sup>15</sup> The demonstration project will determine whether Medicare medical homes improve the quality of health care Medicare patients receive "by avoiding inconsistent treatments and medications, increasing the amount of preventative care, and improving patient adherence" and reduce costs "by avoiding

# ASHP Policy Analysis

unnecessary care, rationalizing care, and avoiding preventable hospitalizations and readmissions.”<sup>15</sup> It is yet to be determined whether pharmacists will participate at any of the demonstration projects, but the law does not prevent pharmacists from serving as medical home team members.

Demonstration projects will operate in up to eight states in urban, rural, and medically underserved areas. CMS expects that there will be approximately 400 practices with an estimated 2000 physicians coordinating medical home services for about 400,000 Medicare patients.<sup>16</sup> Practices must have NCQA PPC-PCMH medical home designation. CMS prefers that medical homes in this demonstration project operate where Medicare costs are high and, therefore, where there is a greater potential for reducing medical expenditures. Physician practices will begin providing medical home services to patients in January 2010. Medical practices will receive monthly medical home payments from January 2010 to December 2012. The demonstration project ends December 2012, with a project evaluation due December 2013.<sup>15</sup>

The project separates physician practices into two tiers.<sup>15</sup> *Tier 1* or “*typical*” *medical homes* must have 17 basic medical home capabilities, such as the use of a health assessment plan, the use of an integrated care plan, tracking patients’ tests and conducting follow-up services, providing a comprehensive medication review, and referral coordinating. *Tier 2* or “*enhanced*” *medical homes* must meet Tier 1 medical home requirements plus review post-hospitalization medication lists and reconcile with other medications and coordinate patient care, including following up on inpatient and outpatient care. A Tier 2 enhanced medical home also must meet three out of nine optional capabilities, such as using electronic prescribing, performance data to improve results,

and using paper-based or electronic physician reminders to schedule patients for preventative health care services.

## Physician and patient eligibility

Doctors of medicine and doctors of osteopathic medicine are eligible to coordinate medical home services if they provide ambulatory health care services in the family, internal, and/or geriatric medicine practice setting.

Patients are eligible for the demonstration project if they are Medicare fee-for-service patients, are enrolled in both Medicare Parts A and B, and have at least one eligible chronic condition. CMS estimates that 86% of all Medicare patients meet these criteria. The identified chronic conditions include cancer, diabetes, pulmonary heart disease, osteoarthritis.<sup>17</sup>

Patients are ineligible for the demonstration project if they are enrolled in Medicare Advantage, receive Medicare hospice benefits, live in a long-term nursing home facility, receive end-stage renal disease benefits, or are participating in another Medicare demonstration project.<sup>15</sup>

## Payment for medical home services

Practices will receive a monthly care management payment for medical home services recommended to CMS by the American Medical Association’s Relative Value Scale Update Committee. The monthly, per-patient payments vary depending on the complexity of the medical home’s services (i.e., whether it is categorized as Tier 1 or Tier 2) and the severity of the patient’s illnesses. The proposed payment rates are displayed in Table 1. Payments are adjusted according to a patient’s hierarchical condition code (HCC) scores, which reflect disease severity and the burden of care

**Table 1. CMS Medical Home Demonstration Project Payment Rates**

Medical Home Tiers	Monthly Payments Per Member (base rate)	Monthly Payments Per Member for Patients with HCC Scores < 1.6	Monthly Payments Per Member for Patients with HCC Scores ≥ 1.6
Tier 1	\$40.40	\$27.12	\$80.25
Tier 2	\$51.70	\$35.48	\$100.35

## ASHP Policy Analysis

to the physician. Patients with HCC scores < 1.6 are less ill and require less physician effort to manage, while patients with HCC scores  $\geq$  1.6 are more ill and require more physician effort to manage.

### State Health Care Home Programs

The two state health care home programs we examined include an established program and a newer initiative. Community Care of North Carolina (CCNC) demonstrates the effectiveness of a health care home program and is often referred to in the health literature for its scale and success in reducing health care costs. The Louisiana Health Care Redesign Collaborative shows how one state in the early stages of health care reform is testing a variety of health care home methods.

#### Community Care of North Carolina

CCNC, founded in 1998, is a system of 14 community health networks that are organized and operated by local physicians, hospitals, health departments, and departments of social services.<sup>18</sup> As of January 2009, CCNC's 14 networks included 3500 physicians caring for over 970,000 patients participating in Medicaid and North Carolina Health Care for Children (Trygstad T, Community Care of North Carolina, personal communication, 2009 Jan 16).

The current CNCC program is an enhanced fee-for-service model that pays local networks \$2.50 per member, per month for access to acute and preventive services and disease/population management activities.<sup>18</sup> Local networks receive \$3 per patient per month for local case and disease management as well as staff expenses. In addition, local networks receive a total of \$5 per patient per month for patients who are elderly, blind, or have a disability (Trygstad T, Community Care of North Carolina, personal communication, 2009 Jan 16). CNCC-enrolled primary care providers also receive \$2.50 per patient per month for case management services.<sup>19</sup>

A pharmacist participates in a medical home in one of three ways: by working in a clinic, by traveling to where he or she is needed to provide services, or by providing medication management services to a patient referred by either a case manager or a primary care provider. Emphasis is placed on establishing relationships with others on the care team, such as primary care providers, nurse case managers, social workers, health educators, and mental health specialists.

As of January 2009, there were 23 pharmacists working within CCNC's networks on a range of care-improvement initiatives. One initiative, CCNC's Chronic Care Initiative integrates the pharmacist and the care management team with its longitudinal disease management approach that considers all co-morbid conditions simultaneously, rather than focusing on a single disease state. CCNC also established a Transitions of Care program designed to ensure that a patient released from the hospital receives the necessary follow-up care. Under this program, a pharmacist, in conjunction with a case manager, reviews a patient's medications upon admission, during his or her hospital stay, and upon discharge from the hospital, noting any discrepancies, patient behaviors that could affect their medication use compliance, or potential medication-related side effects. This information is sent to the patient's community-based primary care physician, who schedules a follow-up appointment with the patient.

One study reports that CCNC saves the state "at least \$160 million annually."<sup>20</sup>

#### Louisiana Health Care Redesign Collaborative

The Louisiana Health Care Quality Forum defines, implements, manages, and evaluates the Patient-Centered Medical Home (PCMH) program.<sup>21</sup> Because the Forum does not require a physician to head the PCMH, there are opportunities for any licensed health care professional, including a pharmacist, to manage patient care.

Currently, there are four major PCMH projects initiated across Louisiana, including Tiger Care, the Primary Care Access and Stabilization Grant (PCASG) project, the Franciscan Missionaries of Our Lady Health System, and the Region VII Medical Home Demonstration project. PCASG is a 3-year project that started in December 2007 and will continue through September 20, 2010. A fifth project, the Medicaid Provider Service Network Program, is expected to be implemented in 2010.

The four projects currently under way seek to improve the primary care services available to patients. While three projects serve patients of all ages, only Tiger Care focuses on children with special needs. Mental health services are included in Tiger Care and PCASG programs. Project financing comes from a variety of sources, including federal funds, state funds, or a health system's internal funds and payer reimbursement. Tiger Care reported greater family satisfaction with the

# ASHP Policy Analysis

health care services after receiving care coordination. The other three projects do not yet have results available.

## Private Health Care Home Programs

The three private health care home programs we reviewed—Geisinger Health Plan's Personal Health Navigator, Bridges to Excellence's Medical Home Program, and AAFP's TransforMED project—show both national and regional approaches to incorporating health care homes.

### Geisinger

Geisinger Health Plan's Personal Health Navigator, a medical home program, provides patients with 24-hour access to primary and specialty care services, identifies risk trends, and uses "proactive, evidence-based care to reduce hospitalizations, promote health, and optimize management of chronic disease."<sup>22</sup> Launched in January 2007 at two sites, Geisinger phased in another eight sites from October 2007 through January 2008 and an additional 11 sites from August through October 2008 (Tomcavage J, Geisinger Health Plan, personal communication, 2008 Dec 8). The medical home's health care team consists of a physician, a nurse care coordinator, and a personal care navigator to answer patient questions.<sup>22</sup> Pharmacists working within the Geisinger Health Plan are conducting patient case reviews, but the process is not yet formalized (Tomcavage J, Geisinger Health Plan, personal communication, 2008 Dec 8). Geisinger's health plan staff is currently meeting with health care provider groups "to more fully engage pharmacists in the model."<sup>22</sup> A patient's electronic health record is available to all medical home participants, including the patient.

A participating physician receives \$1800 per month to recognize the physician's expanded scope of practice under the program. The practice receives \$5000 per month per every 1000 Medicare patients "to help finance additional staff, support extended hours, and implement other practice-infrastructure changes."<sup>22</sup> The physician stipend for medical home participation represents approximately 5–10% of the physician's salary (Tomcavage J, Geisinger Health Plan, personal communication, 2008 Dec 8). In addition, the physician's practice and medical home team members may receive incentive payments if quality indicators are met.<sup>22</sup> The incentives are "based on differences between the actual and expected total cost of care for medical home enrollees." Eventually, Geisinger expects that the incentive payments will replace the fixed monthly medical home payment.

First-year results from the two pilot sites showed a 20% reduction in all-cause hospital admissions and total medical cost savings of 7%.<sup>22</sup>

### Bridges to Excellence

Bridges to Excellence (BTE), an independent, nonprofit, nationwide physician pay-for-performance program, launched its medical home program in January 2008.<sup>23</sup> Under the program, there are three performance-based levels of recognition for medical homes, with higher performers receiving higher recognition levels and greater compensation. As of December 2008, an estimated 10 to 20 physicians were recognized as BTE medical home providers who serve an estimated 10,000 to 15,000 patients (Machado Jr. EA, Bridges to Excellence, personal communication, 2008 Dec 8). Pharmacists may participate as a medical home team member at the physician's discretion.

Before receiving BTE's medical home program recognition, applicants must first be recognized under three other specified BTE programs.<sup>23</sup> A physician must hold a Level II or a Level III recognition in the program, which requires physicians to implement processes to reduce errors and increase quality, such as maintaining patient registries and using electronic systems to maintain patient records.<sup>24</sup> A physician also must hold a Level II or a Level III recognition in two of three condition-specific programs that recognize physicians' care of patients (cardiovascular disease, diabetes, and subacute or chronic back pain).<sup>23</sup>

A physician who receives BTE medical home designation can receive an annual bonus of \$125 per patient covered by a participating employer, with a suggested \$100,000 maximum yearly incentive per physician. This bonus is in addition to the payments physicians receive for providing care with the condition-specific programs.

### TransforMED

TransforMED is a national demonstration project created by AAFP to assist selected physician practices in implementing the patient-centered medical home.<sup>25</sup> Launched in June 2006 at a cost of \$8 million, this 24-month demonstration project includes 36 family medicine practices around the country. Eighteen practices were assigned a facilitator and given discounted computer software to help implement the model, while the remaining 18 practices implemented the model on their own.

## ASHP Policy Analysis

The TransformMED model of care seeks to improve eight aspects of the health care delivery system: access to information, information systems technology, patient access to care, point-of-care services, practice management, quality and safety, physician office efficiency in how care is provided and practice space is used, and multidisciplinary team approach to providing care. TransformMED does not yet have results.

### Conclusion

Health care home programs being tested regionally and nationally are expected to improve patient care and reduce health care expenditures. How well these programs perform, especially the CMS Medical Home Demonstration Project, will influence whether more payers will be willing to participate in the health care home model. The health care home model has President Obama's support and is included

in early health care reform proposals as a way to ensure that patients get the care they need while also reining in health care spending.

Having a pharmacist on a health care home's staff is essential to achieve the clinical and financial results health insurers, employers, and government agencies expect. However, if a pharmacist wants to be actively involved in health care homes, and potentially health care reform efforts, he or she needs to find physicians who are already coordinating health care homes or who may be interested in participating in such a model. A pharmacist can look to the programs described in this paper to identify those that may be operating in his or her local area. Once a pharmacist has identified a physician who is establishing or considering establishing a health care home, the pharmacist should offer his or her services as a medication expert.

# ASHP Policy Analysis

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