

CAPITOL ASSOCIATES

**Moderator: Bill Finerfrock
November 29, 2011
1:00 pm CT**

Operator: Good day and welcome to the Rural Health Clinics Technical Assistance national teleconference series, Becoming a Patient Centered Medical Home conference call.

During today's conference, you will have the opportunity to ask questions by pressing star 1. Please be aware that you will be prompted to record your first and last name at that time along with your state location and that the recording will be played into the conference prior to your line being opened to ask your question. Also as a reminder, today's conference is being recorded.

And now at this time, I would like to turn the conference over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, Operator and I want to welcome everyone to today's RET teleconference call on Becoming a Patient Centered Medical Home. This is the second in a two-part series on this topic.

Some of you may recall a few months ago, we had a presentation on the whole concept of becoming a Patient Centered Medical Home.

Today, we're pleased to have with us Marge Young, the Executive Director of the Pine Medical Group, and she's joined by Inez Hawes, who is the Clinical Director at the Pine Medical Group, a rural health clinic in Fremont, Michigan that has become certified as a Patient Centered Medical Home.

Ms. Young and Ms. Hawes will talk about the process the clinic went through to become a Patient Centered Medical Home and the value for the clinic and the clinic patients in obtaining this designation.

We anticipate that more and more health plans, including government programs will be looking for clinics to have certification as a PCMH in the future and all RHCs should investigate the opportunity to become certified as a PCMH.

Today's presentation is a wonderful opportunity to learn from an RHC colleague how her clinic was able to obtain this certification.

The format for today's program will consist of approximately 45 minutes for the presentation with remaining time allotted for your questions.

As a reminder, this series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy in conjunction with the National Association of Rural Health Clinics.

The purpose of the Rural Health Clinical Technical Assistance series is to provide RHC staff with valuable technical assistance and RHC specific information.

Today's call is the forty-fourth in the series which began in late 2004. During that time nearly 12,000 individuals have participated on the bi-monthly national teleconferences.

As you know, there is no charge to participate in this series, and we encourage you to refer others who might benefit from the information to sign up to receive announcements regarding dates, topics, and speaker presentations.

You can get that information by going to www.hrsa.gov/ruralhealth/policy/confcall/index.html.

During the Q&A period today we do ask that you provide us with your name and state location before asking your question. If in the future you have suggestions for topics or questions for a speaker, you can send them to info@narhc.org and put RHC TA question in the subject line and we will make every effort to post questions and answers as part of the series.

At this point, I'd like to thank both Marge and Inez for giving their time today to be with us to talk about Patient Centered Medical Homes and the value of becoming one. Marge and Inez, the time is all yours.

Marge Young: Thank you, Bill. First of all, I want to tell you a little bit about Pine Medical just so you'll understand why we took this on from the get go.

And what happened at Pine Medical, we're a multi-specialty group with two offices; about 119 employees including physicians, 13 family practice, two nurse practitioners, three general surgeons, two pediatricians, an ortho surgeon and an ortho PA. Our second office also has an urgent care.

So in the very beginning we were approached by Priority Health, an insurance company in Michigan who asked us if we were interested in becoming a medical home.

And we were circumspect certainly, but we thought that the financial incentives were worth it and we would proceed. We wanted better medical care for our patients of course, but also to be viable financially.

And our medical director was our champion, and he was very much in the forefront of going forward. And I'll tell you, if you don't have a strong medical director, I do not think you could do this program because you've got to have that backing.

The first thing we did, we found from Priority Health that we could go on to a Web site called TransforMED. And we went on the TransforMED Web site and it had a test that we could take for all the domains in the medical home -- and Inez will speak to that in just a second.

But what we did, we began - first the medical director took the test from the professional point of view and then Inez and I each took it to see if our practice actually had the capability to become a Medical Home because if you're starting from zero, this would be pretty tough.

And we thought if we could start perhaps at 50% of the capabilities like having an EMR or having some programming that included the hospital or something like that, we might be able to move forward.

And the three of us took the test and came out with a favorable score and thought at that point okay, let's investigate this and see if we can move forward with this. Inez...

Inez Hawes: What we did then was we took the information in all the domains in the Patient Centered Medical Home outline and I worked with another RN and we actually flipped up all those domains and thought of each task that would have to be accomplished in order to meet the criteria.

We put in all the tasks that we already do and we also added new ones that we thought we should do. And then of course there was a plan - we did like on a storyboard so we had sheets wallpapering one whole office with that whole plan on it. But it also included who was going to do it and how we were going to do it and what timeframe we would do it so we kind of had a starting point.

Because if you look at that whole program and don't take it apart you're just going to be overwhelmed. It's very big.

And even though we were doing - we have always done a lot of pieces of it, how things are documented, how we're recording it, how it's being reported to the insurance companies, etcetera, we had to take a look at all of that over again and make some changes.

Marge Young: And because we're an independent RHC -- so you know what that means; we're out there on our own -- the first thing we did, we talked to the hospital about doing diabetic programs with us because we knew that, you know, that was the easiest thing to grab on to and see what we could do.

So we talked to the hospital -- I had been a hospital administrator for eight years so I kind of knew my way around. And I knew that one of the things that happened in a hospital is very difficult to get patients to the diabetic educator, so here was the low hanging fruit.

And we talked to the nursing director. We put together a program where we would schedule the diabetic patients in our office with our physicians and we would pick a day when the diabetic educator could be on site.

We rented them a room because it's stark, and we walked the patient with the patient's agreement, from the doctor's exam room to the diabetic educator.

And the first day we had eight patients and seven of those patients signed on with the program.

And to this day -- now that was four years ago -- to this day we still have that program in both offices and it's been a very good thing.

Do you want to add anything to that Inez?

Inez Hawes: Just that the hospital has kept track of the HbA1c levels of these patients that are involved in the program and their labs have gone down one whole percentage point.

So we feel that that was enough incentive to keep us going. Its good patient care and the patients really like it because it's individualized.

Marge Young: Yes, and their program increased by 200%. It was quite unbelievable. And it's just been very good. Our patients feel cared about. They keep saying those things that they feel like they're being supported. I keep hearing that from our patients.

One of the ways we made this easier was to interface -- we have an independent lab; Quest Labs -- was to interface the lab with our EMR. Now understand we first had an imaging system which has since become ONC Certified and for meaningful use. So it's quite robust now but it wasn't.

And we were able to interface the lab and then we pulled in a registry called WellCentive and we were able to get the Quest Lab interfaced with WellCentive.

And the registry was free, the interface was free. The lab couldn't hardly wait to do that for us because of course we used them more.

And the registry - everything else we put in the registry, unfortunately we had to do manually. But the registry did give us reports for diabetes and scorecards and showed us when we had gaps and that was wonderful.

And then Inez, do you want to talk about the surveys and how we worked that?

Inez Hawes: For the diabetic patients and that's a program that you'll probably want to start with if you haven't started it already.

Like Marge said, that's easy to start. It's a big population and it affects, you know, all those chronically ill people.

So what we started to do with it is diabetic managers, that we had her give the patients a survey after she got done talking with them and we got that feedback to see how they felt about their care.

And when Marge said that they loved that attention and that attention to their care, those surveys were just really, really positive and that's where we have basis for that information.

Marge Young: And then the next thing we did, we started working on asthma. And we found out that a lot of our staff, including me never understood where asthma became COPD.

So one of our physicians did an in-service - actually we went on the road with this. And he did another one for the community which was really very well received.

But anyway he became the champion of that program and we did that nursing in-service and the nurses loved that. It was wonderful. He taught them how to do teach-backs. Of course a lot of them knew how to do that already.

And then Inez can speak to her - she and the other RNs meeting with the respiratory therapist.

Inez Hawes: We met with the respiratory therapist from the hospital because again we liked to have that partnership. The hospital is right next door to us and very easy to access and we can use them as a resource.

And they also are available for Care Plan meetings, etcetera. If we need them all we have to do is call.

The nurses are doing a good job of teaching patients now about their medication - the long-term and the short acting medications which get a little confusing.

And we also are doing the spirometers and making sure that patients know how to use their inhalers and that teaching element has really helped our asthma patients.

Marge Young: When we were going through this process -- I'm sorry, we're on page - Slide 5 -- when we were going through this process, they have Care Management templates in this WellCentive Registry. But these are certainly - you could put a template into your EMR or you could also use something, you know, with paper.

But the Care Management, when we talk about that this, this other RN that Inez was working with, they were actually job sharing for a while and then she started doing more and more care management.

She had been out of work for a little bit of family time and then came back and started really pushing this Care Management piece and working with the patients, doing action plans with them, outcomes.

Sometimes it meant that a patient would come in and get weighed and talked to the Care Manager for a few minutes. But the fact of the matter is it was support and it was teaching a patient about self management.

Do you want to add to that Inez?

Inez Hawes: It's imperative that you have Care Managers involved with the PCMH when you're setting it up because so much of the information and so much of the patient outcomes and things that you need to document, you're going to need that position in your office if you don't already have it.

And then like we've just expanded it here because Marge has just hired more RNs who are the ones that are qualified to do those teaching and the action plans.

And when we say action plans, these are all in conjunction with the way the physician wants to manage that patient. So there's a lot of communication that takes place around that.

Marge Young: And as you're sitting there thinking, well how are you hiring these people, as we go through these slides I'm going to explain to you as well about the financial piece and how we got there.

And I'm going to regress a little bit. In the very beginning Priority health did offer us a grant that we could -- we had to write the grant. And no dummies, Inez and I we hired a grant writer because we hadn't a clue what we were doing.

And we were able to get a grant that helped pay for some of the things we had to do in the beginning. And that grant was paid out to us over three years and it did help us a little bit to get to where we are. And we knew we'd get enough to afford that first piece of software that we needed.

So they told us it was the best grant they ever read. Yes, that's because...

Inez Hawes: We gave them the information, but we didn't write the grant.

Marge Young: ...but we didn't write the grant, yes. So we could accept the accolades but we did tell the truth. Anyway...

Bill Finerfrock: Marge or Inez, before you get off of that point, you mentioned three years. How long did it take you from the time that you first took your test -- your online test -- until you became a Patient Centered - were certified as a Patient Centered Medical Home?

Marge Young: Well you know Bill -- this is Marge -- we did that with the Blues too. So I'd say yes, I'll bet it was about a year...

Inez Hawes: It was about a year.

Marge Young: ...before we got that first certification. And I think Priority health came through first and then the Blues and then we did the - Inez and our other RN worked on the NCQA. So it was quite a little bit of time.

Inez Hawes: Yes. And all this information overlaps itself. So whoever is planning it and so on has to remember that this is kind of all the same information.

But like the Blues will have it stated one way and Priority Health for the Michigan people anyway, will have it slightly different. NCQA is a little different yet, but it's all the same information and it takes a little while to wade through all of that.

Bill Finerfrock: And the grant, if you're able to say; if you don't that's fine, but how much was the grant? Or if you don't want to give the amount or whatever, but how - was getting the grant critical to your ability to achieve PCMH status?

Marge Young: No, I don't think so. I mean we were going to go anyway. What the grant really did though was it helped pay for the one RN, but it paid for some hardware that we needed the next year because we wanted to have the order module in our EMR so we could follow all our orders.

Thank goodness we did that because now with this new Medicare Transformation Project -- and we'll talk about that at the end -- we absolutely have to have that.

Inez Hawes: It paid for some administrative work too like from our medical director and so on because there are meetings and things that needed to be - you know, that were done.

Bill Finerfrock: Okay.

Marge Young: But we would have done it.

Bill Finerfrock: Okay.

Marge Young: We - just so you know, in this practice -- I came here in October '07, and Inez and the Medical Director had plucked a person out of Medical Records once they went to an EMR.

And that person; all that person did was report quality indicators to our insurance company. They had a very, very extensive quality - because of the extensive quality reporting, they were making great strides in quality money that's being paid back to the practice which we have capitalized on over the last three years. So we'll talk about that at the end.

Bill Finerfrock: Okay.

Marge Young: On Slide 6, and we're talking about the Care Plan visit, a lot of these - you know we're always emphasizing the preventive behaviors. And we're finding, you know, the RNs tell me that a lot of these -- and our LPNs -- a lot of these people don't understand.

You know they hear you say if you don't do A, then B will happen but they really don't believe it's going to happen to them.

And I think when they keep coming in and they're talking with those Care Managers, it does create that trust. And they are seeing that they need to get that HbA1c under seven and it's been a very good thing.

We had one lady in here I think four times before she understood how to really count her carbs; a diabetic. And she had been to the cooking classes with the hospital educator and so that was a win. And she started to get better, but really it was four times.

I've just gone to Slide 7 and this is Marge again. I was at a meeting with the Michigan State Medical Society re: literacy and we decided we would talk about literacy with our patients.

And a lot of patients read at lower than a fifth grade level unfortunately in Michigan; some at a third grade level. And people were having a hard time understating when to take their medications, and I did see an AMA video talking about this.

So a big network in Michigan put on a literacy conference and I pulled together some nurses and the Care Managers. We went to that conference and really got our eyes opened.

What that meant it was free. It was free to go. It was a couple of hours but it was unbelievable what we learned there.

And so people were understanding about the barriers. We've had to make signs for people's refrigerators because they don't understand T is Tuesday and TH is Thursday, and they weren't taking their meds right.

And we had to color code a chart for meds, so that was - that's been a win; a big win.

And then the hospital discharge is on this slide. We're beginning - well we did have - we did follow some people in the hospital. Do you want to address that a little bit Inez?

Inez Hawes: Yes. Every morning we get a list from the hospital of which patients - Pine Medical patients are there and their diagnosis. So the Care Manager has started a long time ago already, looking at those people.

And if there is a diabetic quite often she would just check with the physician to see if there was a role for her to play before they left the hospital. Or when they got home they'd get a phone call.

And we're doing that now pretty consistently is they get a phone call, you know, did you make your follow-up appointment, is everything going okay, do you have any questions; that kind of thing.

So that has really - all it does it build a relationship with these patients that they trust you enough to call you when they're having problems and we can help with their care, so that's quite effective.

Marge Young: Yes, it's been nice. We can make sure we get them into the office when we need to and, you know, there's a whole transition there.

On Slide 8, the lunch and learns, I mentioned that before with one of our physicians who did a little outreach in the community which we will continue with different topics.

We did do some interviews on the radio which actually was free. And our physicians could be on that radio and, you know, we had a list of questions they were asked.

And we also ran a DVD and we played it on that and bought a flat screen and put it in our waiting room and played the and used that for a marketing tool also.

And then the biggie came - the NCQA Level III. So here we are working with Priority Health for the Medical Home. We're also working with the Blues. And then priority Health says well you can make X amount of dollars if you become NCQA certified, so I'll let Inez tell you a little bit about that.

Inez Hawes: We didn't realize when we agreed to do this how much work that was going to be. And we laugh about it because we kind of went into it blindly.

We went to one conference - Marge and I went to once conference and thought oh, we can do this. Well that's a process. That program is quite detailed, but what it really did was it made us examine every single process in this office from how orders are taken to the follow-up with the patient.

I mean everything in-between, how the lab works, how we do call backs on appointments, how do we let people know what we have openings for appointments, it covers a wide range of things.

And two of us like we said before, have worked on this and we ended up getting a Level III which was the highest level. It took us two tries to get there, but what a learning experience.

And I think it has really impacted the processes in the office and it also because of that has impacted patient care and we feel pretty good about that. That was a biggie.

Now for - I would suggest if you're Michigan people, Priority Health has a nurse consultant that will help you a lot with this, and probably the blues do too, although I did not work with them because we were doing this with Priority Health.

But her name is (Cathy Johnson) and she was excellent at saying, you know, have you thought of this and have you thought of that. So, you know, when you get bogged down in some of this, you might want to work with a consultant.

Marge Young: And then the next bullet point talks about office information. You know we just made sure we had a lot of educational things available. When we got this Level III and when we got some quality awards which is mentioned here, we had pictures taken of staff, we hung them in our offices and put our awards up.

And I will - to be honest with you we were such good reporters of what we were doing, you know, I'm sure the majority of physicians were wonderful. But if you don't tell somebody what you're doing, they can't give you a quality award.

So we were experts in reporting, but the truth of the matter is we do have very, very good outcomes. And I think they've gotten better since we've done all these things and so that's been a very good thing.

So the office information with educational handouts like I talked about, and then our Web site, you know, the first quote was \$7000. And after I, you know, caught my breath I found somebody for

200 bucks, got us a Web site going and then I sent an administrative assistant to a class and she learned how to put that all together.

And we have streaming; we have a link to Bill Pay with Med Fusion. And it's very inexpensive the way we did it, but we just kind of refused to...

Inez Hawes: ((inaudible)).

Marge Young: Yes, and we have on that Web site we have our PCMH information. If you want to go on Pinemed.com you can see that, all our doctors and bios on them, it's quite lovely actually.

And then the financial piece, I'll address that towards the end. The strategy and the evals, Inez and I, we had had a strategic planning meeting and being a hospital person in the middle of my career, I knew that I wanted those evals to reflect the strategy of the organization.

So we went back through those and Inez redid the nursing and we gave them the competencies that we knew we needed to hit the pieces of the NCQA and the PCMH domain so we could be right on target.

And oddly enough we had two billers go to a seminar and we got a call the next day from the seminar people and they said the only people in the room that knew what a Medical Home was, so we were pretty happy about that.

So obviously we got our point across because we hammered and we still, every meeting we have in this office that is one of the agenda items. PCMH, you have to continue, continue with it or you'll lose track of it.

And then Slide 9, Urgent Care. This was an experience. You want to talk about that Inez?

Inez Hawes: I think it's been in - I think our Urgent Care started about two and a half years ago. And Marge and the Board decided that that would be a good thing for us to do in our satellite office and it's been wonderful.

We are seeing patients what we would not see otherwise. It's open every day Monday through Friday; a little bit more during the summer hours because Newaygo, Michigan where our office is is a resort area. So we get all the people that are camping there.

It's really opened up access for patients in the area. It actually is an extension of our office and can also take - we take patients that can't get in during the day or for some reason or another a problem happens, you know, in the evenings they can go to the Urgent Care.

We did write a whole different set of policies and procedures for urgent care because it's not the same as your regular office. So if that's in the planning, you know, really look to see what urgent care is, what types of patients you're going to be taking care of, and make a little separate policy manual for that. And that has worked out very well for us.

Marge Young: And Inez and I have gone over and visited a dear friend of mine in another county who also had an Urgent Care office extension type one and we looked at what they were doing. It was doing very well for them, also in a resort area.

A lot of you would know her, (Colleen Johnson). And she was fabulous to us and we took our President of our group there and met with them. And then we were able to move forward.

There was no urgent care in our county, so that's been a wonderful thing. And we have a group of PAs that come in and help with our work, but that gives us a lot of access for people, so that's been very good.

And then Patient Advocates - Slide 10, when I came to Pine they already had a Patient Advocate that helped patients with all the things you see here - Medicaid apps, MI Child, medication, free medication, help at home, rides for appointments.

And we expanded her role. Inez and I, every free thing we came across we gave to her. She really was a prepaid for uninsured for surgery, but we sent her over to the hospital, we had her learn the charity care process over there which I had done at the hospital. That was part of what I managed.

So we went - we decided to go with the sliding fee scale because that would help for recruiting with our physicians because we could loan repayments for them through NHSC. And our doctors, you know, part of their mission is to take care of those folks.

So it was just a win/win all the way around and she's just been wonderful for people. It also takes some of the form work off our nurses and our doctors and it's been a good thing.

And as we move into this next thing - Medicare Transformation Project - she's going to be a vital part of that.

And do you have anything to add about that Inez?

Inez Hawes: No.

Marge Young: Okay. Financial Benefits - so as you realize now, we're in two medical homes, Priority Health and the Blues.

We do have to - oh, I'm sorry, I'm missing - am I missing a slide? Oh I'm sorry, I went right by 12.
I apologize.

WellCentive - we put this registry in. It is not interfaced with our EMR; it's going to be soon thank goodness. This is - this really helps because it downloads to the HMOs and it's been a very good thing.

It's been a lot of work but it's put everything in one place. We've got our mamms in there, our screening colons, but all our chronic diseases, and we've got those lab interfacings.

And then the eScribe SureScripts is in our EMR. That's automatic as you know. I'm sure many of you have that - have a different kind that had that in there.

Do you want to mention anything about this Inez?

Inez Hawes: I think the key for this is that we look at the schedule - patient schedules a day ahead of time and see who's coming in for an appointment. And we can run the summary sheet off of the registry and find the gaps of care so what when that patient comes in the door the nurse and the physician know what areas they might want to focus on for that patient.

Whether they need some lab work done or they need a test done or maybe they had it done and if it's not in WellCentive yet, that happens too. But at least we can have a clue so that when we have that patient in the door that we are doing what we're supposed to be doing what we're supposed to be doing for them or what's suggested that we do for them.

And that has really helped our reporting I can't even tell you how much because it just - it identifies all these different areas that maybe weren't done on a previous visit or that ((inaudible)).

Marge Young: We were very happy because last year I think we had two quality awards - one from Health Plan of Michigan, one from Priority Health and one from the Blues. But we also got nationally recognized by the Primary Care Consortium and had an article written about our diabetic program. So that was a happy thing.

But understand that these Care Managers that take care of those chronics, two of those people already worked here. They were already employees. We have added two more; one has not started yet.

But we're going to increase our care management because in Michigan we're one of eight states that now has the Medicare Transformation Project and that is going to be a huge Care Manager type of situation where we're going to manage all the chronic diseases. So it's going to be very, very busy and we're planning that right now.

And then the financial benefits, Slide 13, like I said, we're in those medical homes. We did receive a 10% uptick or uplift of all the E&M codes for the Blues which we continue to get.

We got an increase of \$3 per member per month with Priority Health because we were NCQA Level III. Now that has ended. Then there were T-codes. Now T-codes, Care Managers can bill, and these are codes that you bill when you're doing a Care Manager visit.

Some companies - Priority Health or the Blues or certain contracts will pay for that done on the phone also.

So the financial incentives of all those ended up to be about \$265,000 a year, although that's decreased a bit. And here's that grant; it was \$145,000 that we were able to get.

The Quality payment, because of our high quality and a lot of that because we've done the Medical Home, we probably have quadrupled that in the last four years.

And I'd say each of the physicians I guess nets out about \$35,000 each. It's quite a bit of money that comes to us from that.

Now this Medicare Demonstration Project, that starts January 12, and it will pay all the Blue Cross Blue Shield Blue Care Network straight Medicaid - I'm sorry, Medicaid HMOs also and straight Medicare, not the Medicare Advantage Plans.

They are going to be paying per member per month to us for care management and that's why we beefed up our management a little bit- our care management.

Bill Finerfrock: And for Medicare is that in addition to your all inclusive rate?

Marge Young: Yes.

Bill Finerfrock: Okay.

Marge Young: Yes it is. And we will have - there are four tiers that they want us to do - navigating the medical neighborhood, and that's why this patient advocate is going to be so very important.

We're going to be coordinating all these referrals and tasks. We already have them in an order module. When they come back we can match them to the orders so we know where everything is going. We have to link to all community services.

So if there is anything out there that someone needs, we can usually match that patient up. And now we've got somebody doing that a little bit part-time in Newaygo. We only have four doctors over in that site.

The next, our Tier I services, transition of care which will be patients that are going to other specialists perhaps to home care, perhaps to LTAC or something. We will have to follow them and keep track of them.

Then the Care Management, the plan visits, we talked about the management support patient ed, even advanced directives and then complex care management which will be palliative care and hospice; that type of thing.

And then they tell you you've got to have that patient access just like we've had with our Medical Home. And we had to be a Medical Home by June of 2010 to be eligible for this program.

So we did make it in and we're signing contracts right now for this to start in January.

Bill Finerfrock: Okay.

Marge Young: Do you have anything you want to add Inez?

Inez Hawes: No, I don't.

Marge Young: Okay. So I think that about wraps it up and Bill.

Bill Finerfrock: Okay yes, I'm here. Operator if you would give the instructions for the questions. And I have a few while we're waiting for people to get into the queue.

Operator: Certainly, sir; thank you. To ask a question, ladies and gentlemen, please press star 1 then record your first and last name when prompted, along with your state location. Once the recording plays into the conference, your line is open and you may proceed with your question. If you're using a speakerphone today, please unmute your phone to allow your voice to be recorded. Again, we do ask that you record your first and last name along with your state location. Again, press star 1 now if you'd like to ask a question. We'll pause for a moment to assemble the queue.

Bill Finerfrock: While we're waiting, either Marge or Inez, is it your sense that the size of your group - you're a little bit bigger I think than the typical Rural Health Clinic or certainly some of the - you know, you're on the larger side.

Marge Young: Right.

Bill Finerfrock: Do you think that that was a factor in your ability to achieve PCMH status or do you think that even a small Rural Health Clinic with a doc and a PA or a doc and a nurse practitioner could achieve PCMH status?

Inez Hawes: I think you can achieve it but you'd have to build relationships with the community, you know, have a real strong relationship with a different specialist in the area and resources from the hospital would use some of that.

But because we're multi-specialty and so on, we had some of that in place already. So yes, I think it can be done, I just think that they have to really have strong relationships with the resources in the community.

Marge Young: And you know something Bill that helped us, our doctors do their own inpatient work and that's a huge thing because we know where those patients are. You know we don't have hospitalists here.

Bill Finerfrock: Right.

Marge Young: Or at least don't use the ones that have come.

Bill Finerfrock: Right. When you started down this path how much were you driven by financial considerations or improving the process and quality of care both; one more than the other? Do you have a sense of what was the significant driving factor?

Inez Hawes: I think that Marge and I worked together really well. She knows the financial side because been her business. I know the clinical side and I've spent many, many years in long-term care where I really understand the process, you know, patient care process.

And between the two of us - I understand the financial side I mean. I know numbers a little bit but I think it took both sides to do this.

Bill Finerfrock: Okay.

Marge Young: I agree. And Bill I was a VP in Finance at a hospital but always on the revenue side for physicians. That was my forte, you know, the charge master and coding and all those things.

So Inez and I, it was a match made in heaven. I mean really we just clicked and we just said we're going to do this.

Inez Hawes: We could see when saw the requirements of the program how it could improve patient care. And for me that was the selling point.

Bill Finerfrock: Okay.

Marge Young: And I have to tell you that was the driving - for me of course it's always going to be financial, especially when the banks are failing. But the truth of the matter is I just think patients deserve the best.

Especially like with that Patient Advocate position you know, we really are doing a full circle around that patient and I love that.

Bill Finerfrock: Operator, do we have questions?

Operator: We do have questions. We'll go to our first caller.

Bill Finerfrock: Go ahead caller.

(Gloria Fuena Dara): (Gloria Fuena Dara).

Bill Finerfrock: Okay. And where are you from?

(Gloria Fuena Dara): Hi. Yes, (Gloria), Greenville Family Health Care in Greenville, New York.

Bill Finerfrock: Hey (Gloria).

(Gloria Fuena Dara): Hi Bill, how are you?

Bill Finerfrock: Good.

(Gloria Fuena Dara): This is great. I was wondering is it a problem - when you talk about community, are there problems with operating with a hospital outside the community?

Inez Hawes: We have in our system, in our EMR system a faxability program that when we contact - we have first of all employees that are designated to do referrals because our practice is kind of on the big side.

And all these referrals to specialists outside of our small community have to be done, you know, every day.

And we have a program built into our EMR where we fax our medical records or parts of the medical records that they need, and we even now have forms that are standardized in our nearby big hospitals that we use the same form to send to all of them. So they're very easy to fill out.

And so we've had to change some things, you know, related to that but that's how you do it. You keep communicating with them.

(Gloria Fuena Dara): Very good. Could you also tell me what's the average salary range for Care Managers?

Marge Young: You know, we pay between probably \$17 and \$20 an hour. But we're very rural. We're about an hour from the biggest - the big health systems and a lot of people that honestly, the last two gals moved back to Fremont and didn't want to work at the hospital; we were very fortunate to get them.

And I know that's not a huge salary for an RN but that has been okay.

(Gloria Fuena Dara): But they're all mainly RNs?

Marge Young: Just the Care Managers, but LPNs are eligible. They have what they call moderate care management and LPNs are billable for those insurance companies. And also in the transformation project was Medicare.

(Gloria Fuena Dara): I see. I'm a PA and I own my practice. And can these facilities be owned by a PA or must they be by a doctor?

Marge Young: You know I don't know the answer to that. I wish I did. I do not know the answer.

I think, you know, we went under criteria for these insurance companies, what they had in mind. So I just don't know because that wasn't a question that we had to ask.

Bill Finerfrock: That used to be a requirement under the NCQA process, but the patient had to be under the care of a physician. But that was changed this past year so that they now will recognize EAs and NPs and the primary provider of care.

(Gloria Fuena Dara): Wonderful.

Bill Finerfrock: So I don't know that the ownership issue is the question so much as who's the primary provider of care for the patient. And they will now recognize both e PAs and NPs.

Marge Young: Good.

Inez Hawes: That's wonderful.

(Gloria Fuena Dara): Okay, thank you very much.

Bill Finerfrock: Okay. Next question operator.

Operator: Certainly. We'll go to our next question from...

(Doris McFarland): (Doris McFarland).

Bill Finerfrock: Go ahead (Doris). Where are you from?

(Doris McFarland): I'm from Hillsboro, Illinois, a small rural Health Clinic in the country. But I missed the Web site for the slides and that's really what I'm asking for.

Marge Young: Oh, it's just www.pinemed.com.

Bill Finerfrock: That's for you.

Marge Young: Oh I'm sorry, you're talking about this program?

(Doris McFarland): Right.

Bill Finerfrock: You can go to the Office of Rural Health Policy Web site and download the slides. It's www.hrsa.gov/ruralhealth/policy/confcall/index.html. And if that still doesn't work just send an email to info@nrhc.org and I'll get you the slides.

(Doris McFarland): Okay, thank you very much.

Bill Finerfrock: Okay, next question?

Operator: The next question will come from...

(Paula Arret): (Paula Arret), Washington State.

Bill Finerfrock: Go ahead (Paula).

(Paula Arret): Actually I have two questions. First it was stated that this was being recorded. Where will we get access to the recording?

Bill Finerfrock: It's at that - it will be on that same Web site. We have to wait until the transcript has been edited and available before we can post the recording. Generally it should be ten days to two weeks available for the record and the slides are all at that same site.

(Paula Arret): Okay. And at the beginning you stated that it took approximately one year from the time you took the test to be certified. Did you have dedicated fulltime staff to this process?

I'm making the assumption that the two of you had other responsibilities and were not just working on this certification.

Marge Young: While we did have other responsibilities, but we were the ones that worked on the certification. Yes, we did it.

Inez Hawes: We did it along with our regular jobs.

(Paula Arret): Okay. How much time do you think you spent on this, 40% of our time, 50%?

Marge Young: No, you know, we had a standing meeting every Tuesday and we just planned every Tuesday afternoon that's what we were going to do, so may 30%.

Inez Hawes: That was on the clinical side.

Marge Young: Yes, on the clinical side. And I think for me it was I'd say about 20%.

(Paula Arret): Okay, thank you.

Bill Finerfrock: Okay, thanks (Paula). Next question.

Operator: And that question will come from...

(Carol Brinker): (Carol Brinker).

Bill Finerfrock: Hey (Carol).

(Carol Brinker): Hi, I'm from Iowa. My question is regarding your - I'm very interested in your diabetes ed program, and who is the hospital you collaborate with?

Marge Young: Was it was Gerber Memorial but it is now Spectrum Health Group for Memorial, so it's been bought out by a big hospital down in Grand Rapids, Michigan. We're an hour North of there.

But I'll tell you, that diabetic program, I used to be a revenue person at a hospital and I actually ran a small campus for a hospital. And I wanted that diabetic education piece because the educator kept telling me, I never have any patients.

And I went to the hospital and luckily the CNO was very nice about it and she - I said to her, "I really can sell your program. You've just got to bring me an educator."

But I did explain to them - and I knew this because I'd been in finance at a hospital, that on the hospital side their educator can bill a G-code and be paid. And they were unaware of that up here.

And so when they looked in to it they found out yes indeed, they could be paid and they were willing then to go ahead and start the program.

Bill Finerfrock: And Marge, how big is Gerber; how many beds?

Marge Young: It's 80 - it was 81 beds.

Inez Hawes: They've downsized.

Marge Young: they downsized. It's about 63 beds I believe.

Bill Finerfrock: Okay.

(Carol Brinker): Okay. So the billing is done through the hospital side and the delivery is done in the clinic, is that what...

Marge Young: Well they bill their G-code in their system. They pay us a little bit of rent for the room and then we bill our Care Management side in our system. So they're actually billing a UB hospital and we're billing a Part A, UB for Care Management, you know, in the program.

(Carol Brinker): Okay.

Marge Young: But yes, that's how that works.

(Carol Brinker): And you mentioned there was an article written about the program. What journal was that in?

Marge Young: Yes, it was in that Primary Care Collaborative. I've got it here some place. It's a wonderful article.

Bill Finerfrock: If you want - if you'll send me that article we will send it out to the folks on the LISTSERV.

Marge Young: Okay, I will do that.

(Carol Brinker): Okay.

Bill Finerfrock: So anybody who is on the LISTSERV.

Marge Young: Okay, I will do that.

Bill Finerfrock: So anyone who is on the LISTSERV, if we get it from Marge you will get it through the Rural Health Clinic technical systems LISTSERV.

Marge Young: Great, I will do that.

(Carol Brinker): Okay, thank you very much.

Marge Young: Thank you.

Bill Finerfrock: Next question operator? And how many do we have in the queue yet?

Operator: There are still five in queue.

Bill Finerfrock: Okay, we'll try and get to as many as we can.

Operator: And we'll go next to...

(Jennifer Jones): (Jennifer Jones) with Harmony Health Medical Clinic in California, Uva County.

Bill Finerfrock: Go ahead (Jennifer).

(Jennifer Jones): Hi. I just wanted to find out if Pine Medical Group was for-profit or a non-profit?

Marge Young: It's for-profit but we still have the sliding fee scale. Yes, we are for-profit.

(Jennifer Jones): Okay, so you don't have a Board, you just have the Director?

Marge Young: Oh no, we have a Board. All our doctors are shareholders on that Board.

(Jennifer Jones): Okay, okay. And then I have one other question.

Marge Young: It's not a traditional Board, no.

(Jennifer Jones): Okay, that answers that. And then do you have to be a community clinic?

Bill Finerfrock: I'm not familiar with that term. What do you mean by a community clinic?

Marge Young: We didn't have...

(Jennifer Jones): A county clinic.

Marge Young:...a Rural Health Clinic or we could have been a private office that wasn't in a rural community. Are you talking about like a FQHC?

(Jennifer Jones): Correct.

Marge Young: Okay.

(Jennifer Jones): And you are a RHC, correct?

Marge Young: We are a RHC. I have friends that, you know, FQHCs also qualify.

(Jennifer Jones): Okay, thank you.

Bill Finerfrock: Okay, next question.

Operator: And we'll go to our next question.

(Julie Amon): (Julie Amon).

Bill Finerfrock: Go ahead, I could barely hear that but go ahead next caller - question.

(Julie Amon): This is (Julie) from Southern Illinois.

Bill Finerfrock: Hi (Julie).

(Julie Amon): I understand with the Patient Centered Medical Home part of the requirement is to have available 24-hour access to care. And would you mind speaking to how you manage that or share that in your medical practice?

Marge Young: Sure. Our office is open from about 8:00 am until the last person is seen in the evening. We have one doctor who stays.

And believe it or not, our doctor's take calls all night long themselves directly so we could easily meet that domain. So they are on call and answer their phones whenever anybody calls.

Bill Finerfrock: I think that's a great question (Julie) because it's been one of the things that I think folks have kind of looked at with kind of a scratching of their head. So being available does not necessarily mean the doors are open. That having providers who are on call and available by phone can meet that criteria.

Marge Young: That's absolutely right. Yes, if you had an answering service certainly and they could get through to the doctor that qualifies.

Bill Finerfrock: Does that help (Julie)?

(Julie Amon): Yes, it does. Just how are those calls forwarded to the doctor? Do you just simply use a call forwarding mechanism or...

Marge Young: We do.

(Julie Amon):...simply have the hospital refer?

Marge Young: No, they call in to a number at Pine that automatically goes to the physician's cell phone in the evening. Now that's not for our surgeons, that's only for our FPs, but it automatically goes to their cell phones.

(Julie Amon): Thank you.

Bill Finerfrock: Okay, thank you. Next question?

Operator: And the question will come from...

(Chris Bayliss): (Chris Bayliss), Northern California Rural Health Clinic based on a cost.

Bill Finerfrock: Okay, go ahead (Chris).

(Chris Bayliss): Hi, I just have a quick question; I kind of said part of it. We are a Rural Heal Clinic hospital-owned provider based on the campus of a cost. We are getting ready to open a second Rural Health Clinic about 25 miles north.

My question is because we are a non-profit we are part of Catholic Health Care West. Would we still be eligible to look at a Patient Centered Home?

Marge Young: Yes, I don't see any reason why not. We have - our hospital next door to us owns four offices; two they've converted into RHCs, and they've asked us if we would help them become Medical Homes.

(Chris Bayliss): Oh great, that's what I needed to hear.

Marge Young: Okay. Well that's in Michigan so I hope that works for you.

(Chris Bayliss): Well I'll check it in California because I'm sure it will land in my lap if we go forward. But I think it's something that would really benefit our community. We're very, very low income up here.

Marge Young: Oh, well we are too and we think it's been great.

(Chris Bayliss): Thank you.

Bill Finerfrock: Okay, next question. Thanks (Chris). Next question.

Operator: And the next question will come from...

(Barbara Lay): (Barbara Lay), location - West Virginia.

Bill Finerfrock: Go ahead (Barbara).

(Barbara Lay): Hi. I just wanted to check. You referenced being a National Health Service Corp Loan Repayment site...

Marge Young: Yes.

(Barbara Lay):...and I just wondered if you were in a HIPSA or how you obtained that status.

Marge Young: We're in a HIPSA.

(Barbara Lay): Okay.

Marge Young: And we put in the sliding fee scale because we wanted to and realized that that gave us the benefit of getting in the NHFC for the loan repayments for docs. So it was a win/win all the way around.

(Barbara Lay): Thank you.

Bill Finerfrock: And just so you know, that as a Rural Health Clinic you're eligible even if you're in a medically underserved area or a state designated area, you can be designated as a facility designation for purposes of National Health Service Corp simply by virtue of being a Rural Health Clinic and establishing a sliding fee scale, so all Rural Health Clinics have the ability to be a site for the National Health Service Corp. They don't have to be located in a HIPSA in order to be able to do that.

(Barbara Lay): Thank you Bill.

Bill Finerfrock: Sure. Do we have any more questions operator?

Operator: We did have one final question and we'll go to that caller. If you could please, just state your...

Bill Finerfrock: That one and then we'll wrap it up.

Operator: If the caller could just state their name and state location please.

(Kim Shemka): (Kim Shemka), Michigan.

Bill Finerfrock: Go ahead (Kim).

(Kim Shemka): I just was wondering, in the beginning they mentioned about surveys and templates, how did they go about creating those templates?

Bill Finerfrock: Marge or Inez?

(Kim Shemka): Is it just for EMR?

Inez Hawes: Well we actually made our own.

Marge Young: We looked at what we needed to have, you know, what the goals were for the disease and we went ahead and made those templates ourselves.

And when we did this ordering thing, we found out in our office we had 102 forms that people were sending out to order testing and we got that down to about 11. But we made up a generic and kind of demanded that people use it., so it was a good learning experience for us.

(Kim Shemka): And did you do that yourself between the two of you or did you have someone at the office? Was there another person involved in doing that?

Inez Hawes: We can make forms in our EMR and we do have a nurse that's very good at doing it, a lot better than I am. So we do work, you know, that angle.

Marge Young: And then we had our admin go ahead - the administrative assistant that works for the entire group, besides Web site, we sent her to class and she learned how to do all those things.

So we didn't have to hire it out every time so that was helpful. So one person to have some marketing knowledge, the Web site, and some forms control. So we didn't have to go to our EMR every time too and pay them the big bucks.

(Kim Shemka): Yes, and so she's able to update those forms or edit them as needed.

Marge Young: Pretty much. It depends on if it's a barcode situation then sometimes we have to have the EMR people do it. But pretty much we've been able to avoid a lot of costs.

(Kim Shemka): Okay great, thank you.

Bill Finerfrock: Thank you. And that will conclude our call today. And I want to thank both Marge and Inez for the time. This has been very helpful. I think the variety of questions and the diversity and the geographic from the East Coast to the West Coast; from New York to California and places in-between.

So I want to thank all of our participants today for participating. As I mentioned earlier, a transcript for today's presentation will be available at the ORHP Web site in approximately ten days to two weeks.

I also want to remind you to encourage others who may be interested to register for this series. Please share your thoughts and suggestions for future call topics by sending it to info@narhc.org and put RHC TA topic in the email subject line.

And finally I wanted to remind everyone that the next call is tentatively scheduled for January or perhaps February, depending on speaker availability. And a notice will be sent via email to everyone who is part of the RHC TA series, with details on that.

Again, thanks everyone for participating. We look forward to talking to you in a couple of months. Have a wonderful holiday season and a Happy New Year; a safe and Happy New Year to everyone and we'll talk with you some time in early 2012. Take care.

Operator: And again that does conclude today's conference call. We'd like to thank you for your participation.

END