Robert Frost was right when he wrote “Something there is that doesn’t love a wall.” 1 Walls most certainly do not make good neighbors. To connect with neighbors, we must tear down walls: That’s one of the key health care lessons to emerge from the last decade, and it’s the concept underlying the patient-centered medical neighborhood.

M. Carol Greenlee, MD, FACP, FACE, a solo endocrinologist in Grand Junction, Colo., has a vision of the medical neighborhood she’s shared around the country. She is lead author of “The Patient-Centered Medical Home Neighbor: the Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.” 2 The 2010 position paper from the American College of Physicians (ACP) defines the concept of the medical neighborhood and lays out a framework for fostering improved collaboration between the PCMH and its medical neighbors. Greenlee also spoke at the February 2013 Colorado RCCO summit, Making a Medical Neighborhood Happen, co-sponsored by the Colorado Beacon Consortium.

Over the last 125 years, the practice of medicine has, in many ways, improved, she says. However, relationships with colleagues eroded as both scientific knowledge and pressures for productivity grew exponentially. Walls were erected that will be difficult to break down. But Greenlee believes they can come down. The PCMH-neighbor (sometimes called PCMH-N) model offers a way to connect physicians and patients in professional relationships and encourage new types of encounters to enhance access and care.

1 Robert Frost, “Mending Wall”
2 “The Patient-Centered Medical Home Neighbor: The Interface Of The Patient-Centered Medical Home With Specialty/Subspecialty Practices.” American College of Physicians, 2010 (Many of the concepts presented at the meeting and included in this brief reflect ideas presented in this paper. In addition, the website also provides various model documents.)
Defining the neighbor and the neighborhood

At the most basic level, the medical neighborhood refers to the inclusion in and cooperation of subspecialists and other health care professionals with the patient-centered medical home. It offers an infrastructure to coordinate care, not just between that hub and the specialists, but also among specialists and then back to the hub—the PCMH. In that context, a neighbor is one who will

- Communicate, coordinate and integrate with the PCMH as well as with patients.
- Ensure appropriate and timely consultations and referrals.
- Ensure effective, efficient and appropriate flow of information.
- Address responsibility in co-management situations.
- Support patient-centered care, enhanced care access and high levels of care quality and safety.
- Support the PCMH practice as the hub of care and provider of whole-person primary care to the patient.

The concept of a medical neighborhood is both the logical response to the medical home and crucial to the ongoing success—and to the sustainability—of the rapidly evolving health care delivery system.

The PCMH neighbor model complements the medical home, offering shared definitions and expectations for care coordination and communication. As articulated in the ACP position paper, clinical interactions between the PCMH and the PCMH-N can take the following forms:

- Pre-consultation exchange—intended to expedite/prioritize care, or clarify need for a referral.
- Formal consultation—to deal with a discrete question/procedure.
- Co-management
  - Co-management with shared management.
  - Co-management with principal care for the disease.
  - Co-management with principal care of the patient for a consuming illness for a limited period.
- Transfer of the patient to a specialty PCMH for the entirety of care.

Messages to the government: Be flexible

Overcoming the obstacles to a medical neighborhood will likely require federal involvement, Greenlee acknowledges. “We will need flexibility in developing the medical neighborhood, and we need government to support us without being prescriptive.” She has two messages for Washington.

First, policymakers need to pay attention to ongoing medical neighborhood initiatives. “The efforts at the ground level are valuable and deserve attention. Washington needs to recognize the value of these efforts and incorporate them, rather than resorting to top-down mandates.”

Second, Washington needs to “do something about obstructionist EHR vendors,” she says. “Washington needs to understand that the EMR vendors are actually obstructing progress. They should be providing tools, not driving the process. It’s like the oven telling you what you are having for dinner rather than being a tool you use to cook it.”

— M. Carol Greenlee, MD, FACP, FACE
Too many fences, too little communication

“Before I built a wall I’d ask to know
What I was walling in or walling out”
—Robert Frost, “Mending Wall”

The current fragmented and siloed approach to health care delivery wastes resources and imperils patients. Greenlee shared research demonstrating just how broken our system is—and has been for more than a decade:

- Sixty-eight percent of specialists reported receiving no information from the primary care provider prior to referral visits.

- Twenty-eight percent of primary care and 43 percent of specialists are dissatisfied with the information they receive from each other.3

- Twenty-five to 50 percent of referring physicians did not know if patients had seen a specialist.4

There are gaps and there are gaps in the perceptions of gaps, both of which impair care coordination and timely treatment for patients.

Greenlee cited a 2011 study published in the Archives of Internal Medicine.5 It found that while 69.3 percent of PCPs report “always” or “most of the time” sending notification of a patient’s history and reason for consultation to specialists, only 34.8 percent of specialists say they “always” or “most of the time” receive such notification. Meanwhile, although 80.6 percent of specialists say they “always” or “most of the time” send consultation results to the referring PCP, only 62.2 percent of PCPs say they receive them.

That same study found—unsurprisingly—that physicians who did not receive timely communication regarding referrals and consultations were more likely to report their ability to provide high-quality care was threatened.6

A common language: care coordination agreements

The first step to addressing this problem is for the neighbors to speak the same language. It may sound intuitive, but one look at the status quo shows it is anything but. In a medical neighborhood, the neighbors must use the same terminology and the same definitions of terms, Greenlee says. “We need the referral process to be standardized so you know what you are supposed to get when you receive a referral and you know what you are supposed to provide back.”

Once providers start speaking a common language, they can begin to shape care coordination agreements. Those agreements are the structural elements of the model—the foundation on which the neighborhood can be built, she explains. They provide common definitions and expectations, and they spell out the types of referrals, consultations and co-management arrangements as well as the nature of the referral process itself.

They are intended to provide a grid upon which care integration and communication can be built. They establish those common definitions and expectations, but are designed to allow flexibility, based on what works at the local level, she explained.

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As articulated by Greenlee and her colleagues, care coordination agreements include the following elements:

- Definitions of the types of referral, consultation and co-management arrangements available.

- Specificity around who is accountable for which processes and outcomes of care within (any of) the referral, consultation or co-management arrangements.

- The content of a patient transition record/core data set, which travels with the patient in all referral, consultation and co-management arrangements.

- Expectations regarding the information content requirements, as well as the frequency and timeliness of information flow within the referral process. This is a bi-directional process reflecting the needs and preferences of both the referring and consulting physicians or other health care professionals.

- How secondary referrals are to be handled.

- A patient-centered approach, including consideration of patient/family choices, ensuring explanation/clarification of reasons for referral, and subsequent diagnostic or treatment plan and responsibilities of each party.

- Parameters for situations of self-referral by the patient to a PCMH-N practice.

- Clarity around in-patient processes, including notification of admission, secondary referrals, data exchange and transitions into and out of hospital.

- Language emphasizing that, in the event of emergencies or other circumstances in which contact with the PCMH cannot be practicably established, the specialty/subspecialty practice may act urgently to secure appropriate medical care for the patient.

- Mechanisms for:

  - Regular review of the terms of the care coordination agreement by the PCMH and specialty/subspecialty practices.

### Recognizing the neighbors

The ACP position paper that set the PCMH-N concept into motion expressed support for “exploration” of a PCMH-N recognition process. Now, that quest is coming to fruition.

In March 2012, NCQA launched the Patient-Centered Specialty Practice Recognition program. It recognizes specialty practices that have successfully coordinated care with their primary care colleagues and each other, and that meet the goals of providing timely access to care and continuous quality improvement. It is, in effect, the recognition of the medical neighborhood.

Like NCQA’s patient-centered medical home program, the specialty-recognition program will have specific expectations for providing timely access to care and continuous quality improvement. Standards include the following:

- Track and coordinate referrals.
- Provide access and communication.
- Identify and coordinate patient populations.
- Plan and manage care.
- Track and coordinate care.
- Measure and improve performance.

Any eligible clinician who typically receives referrals and can demonstrate a capability to meet the standards may apply. Details, including a link to frequently asked questions, are [here](#).
– The PCMH and specialty/subspecialty practices to periodically evaluate each other’s cooperation with the terms of the care coordination agreement, and the overall quality of care being provided through their joint efforts.

It all begins with the referral, Greenlee explains. That’s the platform on which practices can build. “You have to start at the beginning, but there’s so much that can be built on the platform. It also opens the door for all sorts of wonderful other collaborations in areas such as care plans and patient self-management tools,” she says. “It’s all about establishing relationships.”

Preparing for the inevitable
The move toward team-based, coordinated care will occur whether practices are ready or not. It won’t wait for a common language, and it won’t wait for walls to fall by themselves.

Today, specialists often receive the same reimbursement regardless of whether they communicate and coordinate, she says, but this will change with the move toward shared-savings models, such as ACOs. Moreover, with the move toward a population health approach, primary care practices now realize they are being held responsible for managing quality and costs for their entire population of patients. Care coordination across the continuum is fundamental to the changes happening in health care.

To create a successful, sustainable medical neighborhood, physicians—regardless of specialty—need to rethink their approach to care delivery, she says. “Adjust your mindset and attitude. Think outside your own practice. One of the biggest challenges is to start thinking about ‘my community, my system’ instead of just ‘my practice.’”

Barriers to implementing the neighborhood abound, and it will take more than simply adjusting attitudes and deciding to cooperate. Other challenges include technology issues, payment reform and the need to transform specialty practices in order to enable improved handoffs, care coordination and communication.

About the summit
In February 2013, the Colorado RCCO Leadership Group hosted *Making a Medical Neighborhood Happen*, an invitation-only roundtable summit in Denver co-sponsored by the Colorado Beacon Consortium.

Greenlee; Asaf Bitton, MD, MPH, FACP; Ted Epperly, MD, FAAFP; Paul Grundy, MD, MPH, FACOEM, FACP; David Kendrick, MD, MPH, CEO of MyHealth Access Network; Marjie Harbrecht, MD, CEO of Health TeamWorks, and CBC Executive Director Patrick Gordon all presented at the meeting.

Attendees included participants in the Colorado Comprehensive Primary Care initiative, Medicaid Accountable Care Collaborative and the Colorado Beacon Consortium. They discussed potential solutions and best practices for the use of technology and payment reform to support better coordination among primary care practitioners and specialists. They also discussed Colorado health care reforms, broad population health improvement efforts and federal initiatives to support these efforts—including, notably, the Comprehensive Primary Care initiative, with its focus on active engagement and care coordination across the medical neighborhood.

It was a crucial meeting, Greenlee says. “The reason *Making a Medical Neighborhood Happen* was so important is that it brought together the ideas and the energy needed to actually create that neighborhood and move it forward.”

Payment reform essential
Many of the challenges to building a medical neighborhood are rooted in the current payment system. Payment reform is essential to any transformation. Incentives need to be aligned with the changes required to become a good medical
Colorado in the forefront

Greenlee is particularly gratified by the progress—and the attitude—in Colorado. “Elsewhere, I encountered considerable resistance, but not in Colorado. Various communities have been working on this, including where I live. It’s growing spontaneously.”

One reason is that various areas in the state were already advancing the medical home and other primary care efforts. That provided a basis for a neighborhood: “Once you get your hub secured, you need those spokes,” she says. Western Colorado, in particular, has been putting those spokes in place. Mesa County Physicians IPA has been working on the medical neighborhood since 2011. Several of the Beacon practices are starting to roll out their own neighbor agreements. In addition, Quality Health Network has provided tools to help specialists make the necessary changes. “It’s wonderful to have my own community be one of the early responders.”

Greenlee has some ideas about why Colorado has been so receptive. “One of the most notable attributes of Colorado health care providers is their ability to work together as a community—to integrate and to hold each other accountable—while remaining independent.”

Addressing payment mechanisms—how to structure and provide incentives—must be part of building the neighborhood. Greenlee points out there are many incentive structures available to recognize the efforts—the medical home efforts can provide a guide. As the position paper points out, “the implementation of various incentive structures in present and newly developed PCMH demonstration projects will help determine the most effective and efficient ways of providing this important recognition.”

And these reimbursement issues that have been a challenge for medical homes will likewise challenge medical neighborhoods. For example, practices are transforming themselves into medical homes, but they are only paid to do so for certain payers’ patients. This issue is being addressed in the CMS Comprehensive Primary Care initiative, but many other practices across the country are not being “made whole” in terms of payment for the work they are doing. Without payment reform—which involves active payer cooperation—those same problems will beset the entire neighborhood.

Practice transformation: not just for primary care

Becoming part of a medical neighborhood requires practice transformation—something that’s second nature for many primary care practices, but foreign to many subspecialists. “We’re learning there’s a lot of transformation in the specialty practice that has to happen,” she explains.

Internal practice changes will be required to coordinate and communicate better between and among practices—changes in workflow, procedures, policies, etc. “Considerable time, effort and money has been made available to help primary care practices transform,” Greenlee says. “It is much harder to find any type of education or support for specialty practices on how to adapt, change or transform. We saw this same thing with Meaningful Use; there were regional centers to help primary care practices, but no support for the specialty practice.”

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Health IT is a tool, not a driver

Technology vendors need to adapt as well, she says. “Right now the EMRs do not always make it easy to take care of patients and to do what we need to do inside of specialist practices,” she says. “Physicians and staff are being drowned in ‘clicks’ and opening—and then closing—countless boxes. We really need the EMR vendors to listen to what is needed, to stop worrying so much about competing and ‘proprietary’ issues, and truly help make for a less cumbersome system within which to exchange data.”

Other challenges

Technology, practice transformation, payment reform and mindset are only some of the barriers to building a viable medical neighborhood. Among the others:

- Patient engagement—the patient and caregivers need to be included at the table.
- Integrated behavioral health—challenges for sharing data and integrating physical and behavioral health.
- Engaging specialists—giving them a voice and helping them understand the medical home concept.
- Secure communication and e-consults.
- Metrics for success.

Greenlee believes these issues can be resolved. But it won’t be easy. She offers another piece of advice for physicians ready to take this on: “Prepare inside your own practice and your workflows so you can be ready to make changes outside your practice.”

Moving ahead

Greenlee has witnessed tremendous strides since 2007, when ACP’s Council of Subspecialty Societies Workgroup on PCMH-N—which developed the position paper—was formed. Around the country, collaborative groups are formally working on the PCMH-N, while other groups are developing similar arrangements on their own, she reports.

For example, the Vermont Blueprint for Health is implementing a neighborhood program under which medical homes and certain subspecialty practices share a monthly care coordination fee for the treatment of COPD, CHF, diabetes and asthma. The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most-frequently referred-to specialists and hospitals. (For developments in Colorado, see "Colorado on the forefront" on page 6.)

We saw this same thing with Meaningful Use; there were regional centers to help primary care practices, but no support for the specialty practice.

— M. Carol Greenlee, MD, FACP, FACE

She emphasizes that the PCMH-N model is flexible. “Within any institution or community, the platform will have its own variations based on its particular characteristics—shared EMR, employed physicians or not, sophisticated HIE, etc...,” she says. “We still individualize care for each patient, we just know what we are asking for when we request a certain type of referral, we know what we should get back, we know what was done and who is accountable for which aspect of care.”

Meanwhile, new models and metrics continue to emerge. For example, the medical neighborhood is an explicit part of the CPC initiative. The American Board of Internal Medicine is using the medical neighborhood model as the basis for a new care coordination practice improvement module for board certification and re-certification, providing a survey tool for the process. In addition, NCQA recently launched a specialty practice recognition program (see sidebar on page 4).

“It’s exciting, but exciting and easy aren’t the same thing. This will require a lot of hard work, because the current situation is terrible,” she says. “The embarrassing thing is, we should have been doing this already. It’s been a missing link.”
M. CAROL GREENLEE, MD, FACP, FACE is board certified in Internal Medicine and in Endocrinology, Diabetes and Metabolism and is in a private solo endocrinology practice in Grand Junction, Colo. She has a passion for the care of her patients and has found a passion for improving care delivery in the bigger system of care, especially integration of care and communication between clinicians and with patients.

She is the current vice-chair of the Counsel of Subspecialty Societies for the ACP, as well as a co-chair of the CSS Work Group on PCMH-Neighbor and was a lead author of the ACP position paper “The Patient-Centered Medical Home Neighbor: the Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.” She is a member of the ABIM Care Coordination Practice Improvement Module (PIM) Committee, the NCQA Clinical Programs Committee and the NCQA Specialty Practice Recognition Advisory Committee.

Dr. Greenlee currently has a seat on the Council of The Endocrine Society, where she also has served on the Clinical Affairs Core Committee, and chairs the Clinical Practice Task Force and the workgroup on Shared Decision Making for insulin management. She serves on The Endocrine Society Thyroid Nodule PIM development committee as well as on their Transitions of Care task force, developing tools for assisting pediatric to adult care transitions. She served on the board of directors for the American Thyroid Association, chaired their Clinical Affairs Committee and the Task Force on Radioiodine Safety and served on the Hyperthyroid Guidelines Writing Committee.

In her local community she is active in the Mesa County Physicians IPA, serving as chair of the Clinical Integration Committee and on the Primary Care and Specialty Incentive Design committees. She is on the faculty of the Colorado Beacon Learning Consortium for western Colorado, where she has presented workshops on population management in diabetes care as well as on the Medical Neighborhood.

She graduated Summa Cum Laude from Miami University (Ohio) and with Highest Distinction from Indiana University School of Medicine. She did her Internal Medicine internship and residency at Ball Memorial Hospital in Muncie, IN before returning to IU medical center for her fellowship in Endocrinology.

Pertinent Publications:

About the Colorado Beacon Consortium
The Colorado Beacon Consortium is made up of executive-level representation from four mission-driven, not-for-profit, Western Colorado-based organizations, all of which have nationally acknowledged track records of coordination to achieve superior outcomes. They are Mesa County Physicians IPA, Quality Health Network, Rocky Mountain Health Plans and St. Mary’s Regional Medical Center. The Colorado Beacon Consortium’s mission is to optimize the efficiency, quality and performance of our health care system, and integrate the delivery of care and use of clinical information to improve community health. The geographic focus of the Consortium’s activities includes the Colorado counties of Mesa, Delta, Montrose, Garfield, Gunnison, Pitkin and Rio Blanco.