

The Medical Home Model Holds Promise for Strengthened Healthcare Delivery, Greater Pathology Role

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Even as proposed insurance reforms garner most of the attention in the national healthcare debate, a growing number of providers and payors are quietly working together to fundamentally restructure the healthcare delivery system.

At the center of these efforts is the so-called medical home, a collaborative, patient-focused, team-oriented delivery model that gives designated physician practices new responsibilities for coordinating all elements of the patient care process.

Proponents of the medical home model believe the approach can reduce costs while improving accessibility, continuity, accountability and outcomes. Like the hub in a wheel, the medical home physician coordinates patient care with the various specialist “spokes” while retaining overall responsibility for the patient’s well-being.

Although most descriptions of the medical home model currently place primary care physicians and their

patients at the center of the process, it is possible that certain specialists could become medical home leaders for those individuals with complex, chronic conditions. Moreover, the medical home “team” doesn’t necessarily need to exist within a specific practice location but instead can be integrated using existing, stand-alone groups and resources in a collaborative approach.

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Some advocates see an expanded role for pathologists in the model, given the primacy of laboratory data in the diagnosis and treatment of illness. However, it is not clear that the benefits of

either readily accessible lab information or closer collaboration between pathologists and primary care physicians is readily understood by many proponents of the medical home model.

Emerging Consensus

In recent months, a consensus appears to be growing that the medical home – by virtue of its potential to significantly improve care while reducing costs – may offer real hope for reconstituting the U.S. healthcare system. Numerous medical societies, payor organizations and corporate purchasers have endorsed the model, as has President Obama, who has said that any healthcare bill should “encourage and provide appropriate payment for providers who implement the medical-home model.”¹

Yet experts warn that the road from concept to reality will not be easy. Despite the promise of the medical home model, many questions and barriers exist. Chief among these barriers is the acute shortage of primary care physicians nationwide. Because primary

care doctors are central to the success of the model – at least as the model is currently envisioned – new methods must be devised to bring more doctors to the field.

At the same time, alternative reimbursement methodologies must be constructed that reward the cognitive and consultative services at the heart of the medical home model. Strategies also need to be developed to better use nurse practitioners and physician assistants in lieu of available primary care physicians. Also, the uncertainty about how relationships between primary care doctors and specialists would be structured and under what circumstances specialists could or should become medical homes must be resolved.

Whether the medical home can become the centerpiece of a revitalized healthcare system likely will depend on the numerous demonstration projects planned or currently under way. Since early results appear promising, physicians, hospitals and related organizations would do well to review the criteria for becoming a medical home, assess what components they may currently lack or possess and determine whether, and to what extent, they may want to pursue medical home status. At the same time, providers should be alert to emerging medical home initiatives in their markets.

A Brief History

The term “patient-centered medical home” (PCMH) was coined in 1967 by the American Academy of Pediatrics (AAP) to describe a central location for a child’s medical record. The concept evolved over time and eventually was broadened to encompass all age groups as well as all components of the care process. The AAP and several other medical societies, including the American Academy of Family Physicians (AAFP), reached a consensus definition of the medical home in 2007.² Key elements of the organizations’ “Joint Principles of the Patient-Centered Medical Home” include:

- **Personal Physician:** Each patient has an ongoing relationship with a personal physician who has been trained to provide first-contact care response, as well as continuous and comprehensive care
- **Physician-Directed Medical Practice:** The personal physician leads a team of professionals at the practice level who collectively take responsibility for the ongoing care of patients
- **Whole-Person Orientation:** The personal physician is responsible for providing for the patient’s healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals for all stages of life, including acute care, chronic care, preventive services and end-of-life care

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- **Coordinated and/or Integrated Care:** Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies and nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they

need and want it in a culturally and linguistically appropriate manner

- **Quality and Safety:** Quality and safety are hallmarks of the medical home and are promoted through such practices as having patients actively involved in decision making, using evidence-based medicine and clinical decision-support tools to guide decision making, and expecting physicians in the practice to accept accountability for continuous quality improvement
- **Enhanced Access:** Enhanced access to care is available through systems such as open-access scheduling, expanded hours and new options for communications (e.g., e-consults) between patients, their personal physician and practice staff³

Gathering Momentum

In addition to the entities that authored the “Joint Principles,” more than a dozen other healthcare organizations, including the American Medical Association, have formally endorsed the medical home guidelines. A consortium of major U.S. employers and primary care physician groups, known as the Patient Centered Primary Care Collaborative (PCPCC), also has formed to advocate for the adoption and testing of the medical home model. The organization currently includes approximately 500 professional medical groups, employers, health benefit companies, national business groups, trade organizations and other entities.

Funding for a Centers for Medicare & Medicaid Services-led medical home demonstration was included in the Tax Relief and Health Care Act of 2006. The large-scale project in eight states will involve 200 practices, 2,000 physicians and 400,000 Medicare beneficiaries with at least one chronic condition.⁴ Although the project was scheduled to start in 2009, the launch has been delayed due to the transition of presidential administrations from Bush to Obama. Separately, however, at least 22 multi-stakeholder medical

home pilot projects currently are underway in 16 states, and eight state programs involving Medicaid beneficiaries are slated to launch in 2009.⁵

Participation Criteria

To ensure consistency among providers, detailed standards have been developed to credential and accredit medical home practices. Two primary certification initiatives have been created thus far: One initiative is led by the National Committee for Quality Assurance (NCQA), and the second initiative is overseen by the Accreditation Association for Ambulatory Health Care (AAAHC.)

The NCQA initiative was developed with collaborative input from a number of leading medical organizations and is focused on nine standards for medical homes:

- Access and communication
- Patient tracking and registry functions
- Case management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improvement
- Advanced electronic communications⁶

Within the standards, 30 elements containing a total of 166 measures have been developed. These measures are applied to a scoring algorithm, which is then used to qualify medical home practices in one of three tiers: Basic, Intermediate or Advanced. (To learn more about the NCQA standards, visit: <http://www.ncqa.org/tabid/631/Default.aspx>.)

The AAAHC accreditation is based on similar criteria but also includes on-site accreditation surveys and care process observation to assess the extent to which practices have met the medical home principles. Details about the AAAHC accreditation process can be found at: <http://www.aaahc.org/eweb/dynamicpage.aspx?webcode=mhathe>.

Multiple Challenges

Because the medical home represents a major departure from the volume-driven, fee-for-service environment that currently dominates healthcare, significant restructuring of provider practices and relationships is necessary to effectively implement the concept. This restructuring, in turn, raises questions about available primary care capacity, reimbursement mechanisms, specialist roles, conversion costs and patient engagement.

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Primary Care Shortage

Arguably, the most daunting challenge facing widespread adoption of the medical home model is the shortage of primary care physicians. A recent report by the Institute of Medicine stated that a shortage of about 16,000 primary care physicians currently exists nationwide.⁷ A second study projects that the shortfall will reach 35,000 to 40,000 physicians by 2025.⁸

The likelihood that the shortage will ease soon seems unlikely. One recent survey of fourth-year medical students revealed that only 2% intend to go into internal medicine.⁹ Indeed, continued low salaries for internists relative to other specialties provide little incentive for medical students to pursue primary medicine.

A survey by Merritt, Hawkins & Associates, the nation's largest healthcare staffing company, recently pegged the average starting salary for family practitioners at \$172,000. That's lower than the starting offering for certified registered nurse anesthetists (\$185,000) and far below the compensation offered to most specialists. Orthopedic surgeons, for example, are offered \$439,000, while radiologists earn an average of \$401,000 in starting salaries.¹⁰

In July 2009, Lori Heim, the president-elect of the American Academy of Family Physicians, told Congress that healthcare reform in any configuration cannot succeed without policies that significantly boost the nation's primary care workforce. Heim proposed that along with increased reimbursement, these policies could include scholarships, debt relief and a range of other incentives.¹¹

In the face of the shortage of primary care physicians, considerable attention is focused on the role nurse practitioners and physician assistants could play in leading the medical home model.

"Given the current shortage of primary care physicians, the American College of Physicians (ACP) has suggested that the CMS demonstration project should also look at PCMHs headed by an NP [nurse practitioner], rather than a physician," Jeffery P. Harris, M.D., president of the ACP, recently told Medscape Internal Medicine. "This [proposal] was purely a pragmatic issue, because there are obviously situations around the country where a physician is not available, and we need to determine objectively the quality and cost of care provided by an NP-led home."¹²

New Reimbursement Mechanisms

In addition to the structural hurdles posed by the shortage of primary care physicians and the larger issue of disparities between internist and specialist compensation, major questions also exist about how best

to structure reimbursements so as to reflect the additional duties given to principal physicians in the medical home model. Currently, a significant portion of the work is not covered by payors. Central to the model are population management duties that would include case management, quality-improvement activities, team care meetings, IT support, trending and analysis reports, tele-monitoring, home visits, e-mail exchange and other forms of outreach, communication and monitoring.

As part of the “Joint Principles” created by the medical societies in 2007, a hybrid, risk-adjusted payment system was developed to recognize the added work involved in the medical home approach. Components of this pay system include:

- A care coordination fee to cover additional physician, staff and infrastructure costs not recognized under the current Medicare Physician Fee Schedule
- The current, visit-based, fee-for-service payment
- A performance-based fee linked to quality, efficiency and patient experience measures¹³

Writing recently in *Chest Journal*, Neil Kirschner, Ph.D., and Michael S. Barr, M.D., of the American College of Physicians, asserted that the funds to pay for these expanded fees are expected to be generated over time through cost savings resulting from “the systematic way PCMH practices will increase primary care access, coordinate care, use clinical decision support tools to provide evidence-based medicine and manage chronic conditions as well as most other health-related needs.”

The pending CMS Demonstration Project will rely on a payment structure with average, monthly care coordination payments of \$40.40 or \$51.70, depending on the level of medical home status the primary care practice achieves. A number of public-private medical home demonstration

projects already underway offer monthly care coordination payments of between \$3 and \$9 per patient, according to Kirschner and Barr. However, because these payments are significantly below the levels set for the CMS project, some doubt the reimbursements will encourage widespread adoption of the model.

Specialist Involvement

Yet another question involves the role of specialists in the medical home model. Although nothing in the “Joint Principles” necessarily precludes specialists from becoming medical homes, CMS has excluded certain specialties from its pending large-scale demonstration project. Those excluded are radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, psychiatry and surgery.¹⁴

Some have suggested that the medical home could reduce overcrowding in emergency departments.

Earlier this year, a workgroup of the American College of Physicians (ACP) responsible for examining specialty-related medical home issues addressed a number of questions surrounding specialist involvement in the medical home. Among the topics discussed by the ACP Council of Subspecialty Societies Patient-Center Medical Home Workgroup were:

- **Specialist-Led Medical Homes:** Specialists could serve as the principal care hub in the medical home model providing they meet the medical home recognition criteria. “Specialist-led medical homes would be appropriate for many patients with chronic medical conditions.” Examples could include endocrinology practices for patients with diabetes; gastrointestinal practices for

patients with inflammatory bowel disease or hepatitis; infectious disease specialists for HIV-positive patients; rheumatologists for patients with severe rheumatoid arthritis; cardiologists for patients with advanced heart failure; and oncologists for cancer patients.

- **Effect on Referrals:** Noting that the PCMH model is designed to facilitate improved communication and coordination between the personal physician and the specialist, the ACP working group stated that the primary care physician is not a “gatekeeper” and no incentives will exist to limit access to specialists. Instead, primary care physicians should make referrals based upon their clinical judgment while recognizing the needs of the patient. Physicians practicing within a medical home setting would be expected to have systems in place to communicate more effectively with their consultant and care co-management colleagues and thereby improve the referral process.
- **Responsibility for Patient Information Flow:** The medical home practice must have in place the structural capability and systems to effectively assume the role of overall coordinator of care. These requirements include informatics systems to adequately track patient referrals and treatment from the other care providers, medications, and diagnostic tests and laboratory results. The practice also should have the capability to communicate this tracked information, including unsummarized or uninterrupted “raw” data to other participating healthcare teams and to the patient when appropriate.¹⁵

Other Specialty Considerations

Much speculation exists about what the practical effect of widespread medical home adoption would be, both for the system generally and for specialists in particular. Some have suggested that the medical home could reduce overcrowding in

emergency departments. The assumption is that once patients are positioned and comfortable in the medical home practice, their needs for both chronic and acute incidents will be more fully addressed and thus their tendency to rely on the ED will be reduced.

James Crawford, M.D., PhD., is chairman of Pathology and Laboratory Medicine at North Shore-Long Island Jewish Health System in Manhasset, N.Y. He also is a co-chair of a working group associated with the Patient Centered Primary Care Collaborative, a 500-member organization advocating for the testing and adoption of the medical home model.

According to Dr. Crawford, pathology can and should play a central role in the structure of the medical home. He notes the importance of laboratory data in the diagnosis and treatment of disease and the ability of pathologists to serve as partner physicians to primary care doctors in the medical home model. He also points to the role pathology can play in terms of population management to ensure effective, evidence-based testing utilization and interpretation across patient groups.

Despite these benefits, Dr. Crawford said, integrating laboratory services and data into the medical home currently is not a priority in most of the model's early implementations. "The challenge of getting lab data uploaded into electronic health records is not being adequately prioritized," he said. "Without ready access to lab results and the interpretation by the pathologist, achieving quality outcomes and meeting new standards of care will be problematic."

Dr. Crawford emphasized that the importance of the lab in the clinical realm will only increase as molecular testing and personalized medicine become more prevalent. As a result, he believes that if the medical home is to achieve its full potential, it is critical that conduits for timely lab results be incorporated into the electronic

health record (EHR) and mechanisms developed for collaboration between pathologists and primary care doctors. He noted that the College of American Pathologists currently supports the inclusion of pathologists in the CMS medical home demonstration projects.

As is the case with other specialties, major questions surround the structure of reimbursement mechanisms for pathology services in the medical home model. Dr. Crawford said the current payment environment does not recognize the value of either pathologist collaboration with the primary care physician or the collection and management of population-specific aggregate data by the pathologist.

"I think a new reimbursement structure is appropriate and vital," he said. "It's definitely one of the questions that I've faced as I've advocated for pathologist involvement in the medical home."

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Despite concerns, Dr. Crawford said many pathologists are interested in pursuing the medical home model. "What I'm finding is that there is a receptive ear in the pathology community for the role that we can play in helping drive improvements in healthcare and to be a partner to the patient-centered process."

Conversion Costs and Benefits
Given the significant organizational

and process restructuring and technology investments required to become a medical home, the costs of conversion may prove prohibitive for many practices, according to a recent article in *Medical Economics*.

The article stated that a 2008 estimate by the Deloitte Center for Health Solutions put the cost of maintaining a solo primary care physician practice as a medical home at about \$150,000 annually. That amount does not include an initial investment in an EHR system, which can range from \$80,000 to \$120,000 before installation, training and ramp-up costs.¹⁶

Practices that already have transitioned to the medical home model report that while the entry costs are high, the benefits are real. For example, primary care practices involved in the Chronic Care Initiative – a medical home program established in southeast Pennsylvania and supported by three commercial payors and Medicaid – can earn an additional \$85,500 per physician annually under terms agreed upon by Medicaid and the involved payors.¹⁷

A separate demonstration in the Philadelphia area generated an additional \$55,000 for a three-doctor family medicine practice headed by Joseph Mambu, M.D. Dr. Mambu told *Medical Economics* that he expects the program will produce \$108,000 annually, or about \$36,000 per physician, in its second and third year. While the additional revenue is significant, Dr. Mambu noted that – given an initial EHR investment of \$150,000 in 2007 – it would take a total revenue increase of 30% to 50% to cover all costs associated with adoption of the medical home model.¹⁸

Peter B. Anderson, M.D., a primary care physician practicing in Newport News, Va., adopted a medical home model five years ago. His experiences were recently profiled in *BusinessWeek*. Dr. Anderson's practice has three full-time nurses and one part-time nurse. In contrast, most physicians have just one or two nurses. At Dr.

Anderson's practice, the nurses are primarily responsible for updating patient records, a fact that generates major time savings for the physician. One result is that Dr. Anderson is able to see 30 to 35 patients a day, versus the 20 to 25 seen by most practices. Thanks to the increased volume, Dr. Anderson has been able to increase his annual billings by \$200,000 to \$620,000. According to the article, Dr. Anderson's annual compensation is \$240,000 for a 45-hour workweek.¹⁹

Improved Outcomes, Lower Costs

Only time will tell whether the promise of the medical home – improved care and reduced overall healthcare costs – can be realized and sustained. But early results are promising. In one of the first comprehensive evaluations of the model, Seattle-based Group Health reported in September 2009 that a one-year demonstration of the medical home model generated a number of positive outcomes when compared to a nonmedical-home control group. The project included 9,200 patients. Benefits included:

- 29% fewer emergency visits
- 11% fewer hospitalizations that primary care can prevent
- 6% fewer in-person visits
- 94% increase in e-mail use
- 12% more phone consultations
- Longer office visits (30 minutes vs. 20 minutes)
- Fewer patients per primary care physician (1,800 vs. 2,300)
- Patients receiving more comprehensive care, including needed screening tests, management of chronic illnesses and medication monitoring
- Improved patient experience
- Reduced employee burnout²⁰

Robert R. Reid, M.D., Ph.D., Group Health's associate medical director for preventive care, said the medical home model required investing an additional \$16 per patient per year for extra staffing to increase the numbers of primary care physicians, nurses, physician assistants, medical assistants and clinical pharmacists. In addition, medical home patients used, on average, \$37 more in specialty care, perhaps because the enhanced primary care detected previously hidden health problems.

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“Our evaluation showed these costs were recouped within the year,” Dr. Reid said, primarily because of emergency room savings of \$54 per patient in the course of the year.

“These findings are important because they provide a proof-of-concept that investments in the medical home can achieve relatively rapid returns across a range of key outcomes,” Dr. Reid said.

Other evidence supports the viability of the medical home model. More than five years ago, a medical home project called Community Care of North Carolina was established to meet the needs of state Medicaid beneficiaries. Independent assessments have concluded that the program saved the state between \$77 million and \$85 million in fiscal 2005 and between \$154 million and \$170 million in 2006.²¹

A study recently published in the *Journal of the American Academy of*

Pediatrics reported that children with six different chronic health conditions experienced “significantly fewer hospitalizations” when their primary care physicians followed medical home conventions and guidelines. A total of 43 primary care practices were studied in five states and ranked according to a Medical Home Index devised by the Greenfield, N.H.-based Center for Medical Home Improvement.²²

More broadly, maintaining a continuous healing relationship with a personal physician has been shown in a review of 40 studies to significantly improve health outcomes.²³ And the Commonwealth Fund, a private foundation working to promote a high-performing health system, estimates that \$194 billion could be saved over 10 years by assigning each Medicare beneficiary to a medical home.²⁴

Patient Engagement

Because the medical home approach necessarily involves greater patient involvement in the care process, particularly with respect to the management of chronic diseases, ensuring a sustained level of patient engagement remains a major wild card in the medical home concept.

A recent article in *Policy Perspective*, a publication of the Center for Studying Health System Change, stated: “Without a conversation explaining the new medical home model of care, many patients will continue to use care outside of the medical home without telling their medical home physician. If physicians are unaware of the patient's self-referral to specialists or emergency room and hospital use, they cannot help patients coordinate their care.”²⁵

According to the article, evidence suggests that educating patients about the roles and responsibilities of both the medical home physician and the patient can help patients transform the way they use care. In a medical home demonstration project in British Columbia, it was shown that patients' use of specialty, emergency room and primary care delivered by other physicians declined after changes were

made in the registration process and physicians were required to educate patients about the benefits of care continuity.

Looking Ahead

It is impossible to predict the ultimate outcome of current legislative efforts to reform healthcare. But whether medical homes are mandated as part of national healthcare reform or not, market forces may move the system inexorably in that direction.

As such, physician practices should begin assessing their readiness to become a medical home practice by reviewing both NCQA and AAAHC guidelines and accreditation criteria. This process will reveal which capabilities the group may already possess and those that are lacking.

Informatics will figure prominently in the medical home concept. Therefore, primary care groups need to assess their EHR capability to meet the IT requirements of accreditation and credentialing of medical homes. Specialist groups that may wish to become medical homes need to conduct the same analysis.

Specialty practices that do not plan to become medical homes nonetheless will need to have the capability to share information electronically with those practices that do establish themselves as medical homes. Although it has not yet been explicitly stated in medical home discussions and literature, a review of the information currently available relating to data exchange suggests that specialty practices that are unable to easily exchange patient demographic and personal health information electronically in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will likely see decreased referrals from medical home practices. Similarly, groups that seek to pursue the medical home model will increase their chances of success by establishing the capability for HIPAA-compliant electronic data interchange (EDI).

With respect to EDI, all practices should assess their ability to access federal stimulus funds available to support EHR system implementation and other IT upgrades that meet emerging “meaningful-use” criteria. Meaningful use is a key definition that will be used to help determine which physicians and hospitals will be eligible for billions in federal EHR funding made available through the economic stimulus package approved earlier this year.²⁶ Proposed meaningful use criteria are available on the Health and Human Services (HHS) Health IT Policy Committee Web site: <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&parentname=CommunityPage&parentid=1&mode=2>.

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