PRIMARY CARE EXTENSION PROGRAM for ILLINOIS:
History and Vision.
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Implementing system change is never easy. But with the lack of value in the current healthcare system, change is essential. In our own state, Illinois Medicaid is looking ardently for ways to reduce costs while retaining quality of care; the state faces huge financial challenges as it moves towards the enrollment of 600-940,000 new enrollees by 2014 (1). Independent physicians are joining large health systems in record numbers to meet demands for conversion from paper to electronic health records and multiple regional health information exchanges are under development. The trend nationally is to align health care quality with reimbursement, but quality improvements are constrained by changes to the healthcare system alone (2). The data suggests that behavioral changes at home and the removal of social and environmental barriers to care are needed to further improve care and health outcomes.

T**his is a moment to capture**! We have a model of care that has the potential to address the growing asthma, obesity and diabetes epidemics through individual behavior change, through collaboration with local health departments , community based organizations and other municipal agencies to generate environmental as well as health system and policy changes. The intent of this June 17 meeting is to educate stakeholders about PCEP and related models of integrated care and to build consensus for implementing a program of this type in Illinois. At this meeting you will have the opportunity to shape this mode and discuss logistics for implementation in Illinois communities. Please come prepared to be involved by learning about the model, providing ideas about how to become more involved with the group or by providing ideas for implementation.

Welcome.

BACKGROUND

The concept of an integrated network of care, in which medicine and public health are aligned, is not new. But the past twenty years have brought renewed efforts in the U.S. to better link the two systems. (3). These two systems were in fact well integrated prior to the twentieth century. With the advent of bacteriology however, physicians began to increasingly adopt a scientific basis of disease, the biomedical model (4). Disease prevention were relegated to the public health domain, which out of necessity employed a more complex multidisciplinary approach to address the many environmental and social causes of disease (4). Although the twentieth century showed many gains in disease treatment using the biomedical model, care for vulnerable populations in particular suffered with this approach. The many social and cultural barriers to quality care were simply not addressed by a unidimensional scientific approach.

With the aging of the population, the increasing prevalence of chronic disease, and an increasing diversity of the US population, those caring for these populations have sought ways to better integrate a psychosocial model into their care. To address these barriers, community health centers and migrant health worker programs have employed a multidisciplinary approach. Some have hired community health workers (CHW's) to serve as cross cultural case managers and health promoters. Multiple studies

have shown the effectiveness of this approach in the improvement of quality of care and disease control for high risk populations (5,6,7). In developing countries in which the public health and health care services are integrated, this strategy has also been effective for the improvement of public health indices.

Despite evidence that community health workers and teams are useful for improved quality of care improvement, there use has been constrained by questions of payment, as CHW services are not billable in most states. Nevertheless various models have been proposed that utilize the strategy of using community based intermediaries to improve care. These include the Primary Care Extension Program (PCEP), Community-Based Collaborative Care Networks , and Community Health Teams to Support the Patient Centered Medical Home, all of which are contained in the Patient Protection and Affordable Care Act (sections 5405/399W. 10333, and 5042 (8).

In 1998, North Carolina Medicaid launched in *Community Care of North Carolina (CCNC),* a statewide program of 14 local non-profit community networks. Each network is comprised of physicians, hospitals, social service agencies, case managers and county health departments who work together to provide and manage care for their regional Medicare population. Quality metrics are maintained and quality care incentivized. "*According to the National Governors Association/National Association of State Budget Officers State Expenditure Report (published Dec 2009), North Carolina was one of only three states in the nation to have a DECREASE in total Medicaid spending between FY 2008 and FY 2009*". In 2010 CCNC achieved savings of $1.2 billion (9). This model has been showcased as a best practice although not replicated elsewhere.

In 2003, Vermont launched *Blueprint for Health* a quality improvement initiative to improve chronic disease care. This evolved to a model of multi-disciplinary locally-based community health teams supporting primary care medical homes. It was piloted in 2007-2008 in three distinct communities in Vermont. The program continues to grow. In 2011 it will be implemented in all hospital services areas in the state. Details and outcomes of the model will be presented in a separate presentation at this conference by Mr. Steve Maier (10).

As states began to pilot models to enhance primary care at a statewide level, many researchers and policy makers independently explored ways to address the gaps in a fragmented healthcare system. Working from three separate institutions and perspectives, Dr.s Margaret Gadon, Jim Mold and Scott Endsley independently created an alternative model that targeted chronic disease control for vulnerable populations (*integrated network*) in 2006. Their work built off of a program for disease prevention under development by Dr. Mold, which itself was modeled after the U.S. Department of Agriculture (USDA)'s Cooperative Extension Service.[1] The *Integrated network* model built on a triad of the community, the physician office and the public health system, with care coordinated between all sites of health care delivery by a group of "health extension agents" (HEA's) who would also serve as cross cultural brokers between physician offices and the community and public health system. Support was to be provided by

[1] In this USDA program, agricultural extension agents serve as cultural brokers between the farming community and the academic agricultural schools. It was launched as a partnership between the country's land grant universities and the US Department of Agriculture in 1914. Over the next 40 years it led to an agricultural revolution, with the introduction of new farming methods and greatly increased crop yields. As a result food became much more affordable for the rapidly expanding US population. The program continues to this day in its same format.

State -based quality improvement organizations (QIO's),to improve quality, Area health education Centers (AHEC's) for workforce training, and Practice Based Research Networks (PBRN) for evaluation.

Dr. Mold subsequently took this model to his Family Medicine colleagues. Together they refined the model into the Primary Care Extension Program (PCEP). It was incorporated into the 2010 health care reform bill as a strategy for controlling costs and improving quality of care. As described in section 5405(399W) of PPACA , PCEP is a group of state or multistate hubs that support county level networks of care coordination and practice improvement. The State hub is to be composed of representatives from "*the state health department, the state level entity administering Medicare and departments of one or more professional schools that train practitioners in primary care (*10*).* The legislation calls for appropriation of $120 million to fund the state hubs, but unfortunately PCEP has not yet been funded at a federal level.

States nevertheless, have moved ahead with implementation. One benefit of the PCEP model is that it is flexible; it can be modified to promote improvement of healthcare, community health, or both. When applied in New Mexico as the University of New Mexico's Health Science Center HERO's program, community health improvement is the aim. Community based health extension agents (HERO's) "*work with different sectors of the community in identifying high-priority health needs and linking those needs with university resources in education, clinical service and research.*" By addressing the social determinants of disease program leaders believe that health outcomes will be improved at both the individual and population level (11) . Dr. Art Kaufman will be speaking about this program and its outcomes at the PCEP conference.

To adapt a PCEP program in Illinois presents distinct challenges of both a demographic and political nature. There are seven medical schools, and one osteopathic school across the state none of which are charged with regional health improvement. Only one medical school in the state has been active in transforming primary care practices (SIU - Dept of Family Medicine) and only the School of Public Health in addressing community health improvement. There are many resources statewide for healthcare and health improvement outside of the academic world. In the Illinois model we have therefore placed academic institutions in a supportive role, with the community taking a more primary role. In the proposed model, (see Figure 1) regional community health teams assist primary care practices with transformation to medical homes and coordination of care between healthcare delivery sites, provide care management to high risk patients in their community setting and conduct community health promotion under the direction of the local health department. A hub of community based health extension agent teams jointly directed by a consortium of primary care practices and local health department representatives, and an electronic health information system are the core of this concept.

IFMC-IL

Primary Care Extension Program

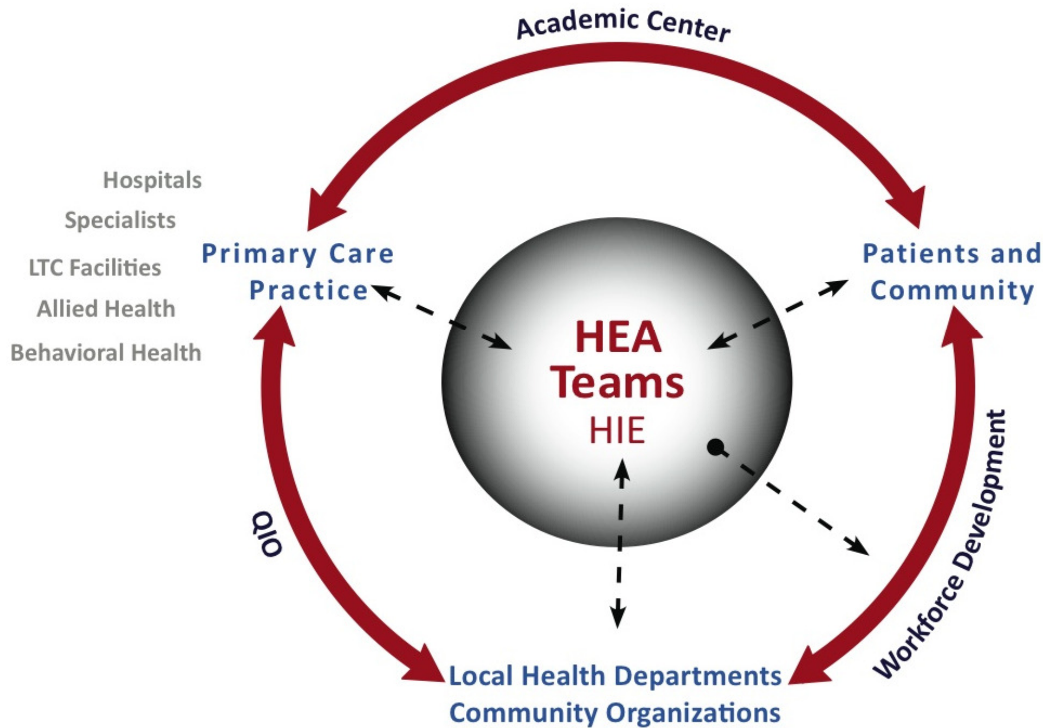

Figure 1. *Proposed PCEP model for Illinois (*Gadon M, 2010, unpublished*)*

This concept was presented to a statewide coalition of health and healthcare stakeholders in September 2010 by Dr. Gadon, clinical director of IFMC-IL, the state QIO. This coalition has been meeting monthly since that time to consider how the concept might be implemented in Illinois. In November 2010 the group decided to hold a conference to engage more stakeholders in the process. Dr. Kirkegaard, Medical Director of Illinois Medicaid directed conference planning. On June 17, 2011, stakeholder organizations and their representatives will be meeting in Chicago to develop and disseminate the idea in Illinois.

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