Integrative Patient-Centered Medical Homes: A Profile of Mountain View Natural Medicine

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INTRODUCTION

This document represents the third installment of a three part series focusing on naturopathic doctors as primary care providers working in Integrative Patient-Centered Medical Homes. In recent years, the convergence of "values-based medicine" under the Affordable Care Act and the rise of integrative health and medicine have increased the opportunities for integrative health providers. However, the roles of the profession that can claim to have first modeled integrative medicine, naturopathic physicians, is modeling these new forms of care are often invisible. This project is meant to help remedy that by creating, posting, highlighting and publicizing a sequence of resources that will become a go-to resource for all stakeholders in understanding these contributions of naturopathic doctors.

The entire project has 3 significant purposes: 1) educate members of the naturopathic profession to these roles for naturopathic physicians; 2) provide guidance for any naturopathic doctors who wish to pursue a professional role in a PCMH or FQHC; and, most importantly, substantially increase awareness that naturopathic physicians have significant roles to play as leaders, and as part of teams, in meeting the nation's primary care needs. The individual case study reports from each clinic are not only intended for integrative providers interested in assuming employment in these settings, but are also for educators, administrators, and other stakeholders to better understand what behaviors and skills are needed to prepare graduates to work in medical homes.

Project Background

Given the context of the dramatically changing health care landscape, the integrative healthcare professions (IHPs) – naturopathic doctors (NDs), chiropractors (DCs), acupuncturists (LAcs)- will play a pivotal role in reducing health care costs, enhancing patient experience, and improving health care (Triple Aim) outcomes while promoting a culture of health and well-being. The patient-centered medical home (PCMH) is a model that has significant potential to improve health care by restructuring how primary care is organized and delivered. PCMHs are closely aligned with the values of integrative health and medicine as they represent a comprehensive, collaborative, team-based approach to care while also focusing on accessibility and coordinated services (Table 1)[1]. Although care in this model has been solely structured around conventional primary care physicians, a few unique new models within the PCMH framework are beginning to evolve that include IHPs as primary care providers. Models like the integrative PCMH (IPCMH) challenge the long-held cultural belief that medical doctors, physician assistants and in some states nurse practitioners, are the only professionals well-qualified to lead PCMHs. Thus far, two states, Vermont and Oregon, recognize NDs as primary care providers eligible to lead PCMHs. Because of the anticipated shortage of primary care physicians in the U.S. and the need to shift our health delivery system to focus on health and well-being, it is an auspicious time to consider innovative models to better understand how integrative providers could help fulfill this shortage while simultaneously contributing to the goals of the Triple Aim and building a culture of health and well-being[2].

[1] Adopted from https://pcmh.ahrq.gov/page/defining-pcmh

[2] *Meeting the Nation's Primary Care Needs*.

Table 1. Central Features of PCMHs (Agency for Healthcare Research and Quality)

Comprehensive Care	The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.
Patient Centered	The primary care medical home provides health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.
Coordinated Care	The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.
Accessible Services	The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access to care.
Quality and Safety	The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

The current model with physician-led PCMHs assumes that MDs have an intricate understanding of the values and practices needed to transform our fractionalized, disease-based health care system to one that is organized around the principles of prevention, health and well-being. With at least 75% of our 3.2 trillion dollars spent on healthcare towards preventable and/or chronic conditions and lifestyle issues, it is time to shift the American health delivery system to focus significantly more on the promotion of health and well-being[3]. Logically, it makes sense to incorporate systems, disciplines, and professionals that already have the knowledge, skills and training to focus on disease prevention and health creation. Integrative Health Providers (IHPs) excel in promoting a culture of health because they undergo in-depth training focused on wellness and prevention, as well as using a less invasive approach before recommending a more invasive one. IHPs emphasize the promotion of self-care, build partnerships with patients, and allow time for office visits that focus on whole person care.

[3] *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html*

Furthermore, IHPs impact patient populations through lifestyle and behavior strategies, but these contributions have largely been under-represented in research, funding and scholarship.

The Academic Collaborative for Integrative Health (ACIH) has received numerous requests from practitioners, stakeholders and constituents wanting to not only know how to start a PCMH, but also how to adopt and incorporate the best practices related to this new and emerging medical model. To broaden our understanding of these clinics, Visual Outcomes and the North American Board of Naturopathic Examiners (NABNE) generously funded this project to explore the role of naturopathic medicine in integrative Patient-Centered Medical Homes (IPCMHs) around the country. The Project for Integrative Health and the Triple Aim (PIHTA), a priority initiative of ACIH, compiles and shares an ever expanding list of IPCMHs in the United States on its website[4]. Due to the collaborative nature ACIH has with existing clinics on this list, 3 were selected to study: The Center for Natural Medicine, Portland, OR, The National University for Natural Medicine, Portland, OR, and Mountain View Natural Medicine, South Burlington, VT. These clinics are located in Oregon and Vermont, two of the most progressive healthcare states in the nation, where naturopathic doctors are eligible to lead PCMHs. Because there exists a paucity of documentation and literature on IPCMHs, this report was drafted as an exploratory attempt to understand some of the issues, barriers, successes and challenges related to the operation of these environments. This document represents findings from conversations held with naturopathic doctors and other integrative providers working in an IPCMH. The information presented below is a broad overview of the development and evolution of Mountain View Natural Medicine (MVNM) as told by providers working in this setting.

Methods

Due to the exploratory nature of this project, qualitative methods were used to capture relevant information from IPCMHs led by naturopathic doctors. As a data collection strategy, interviews were conducted with staff working within these clinics to capture and catalogue information about their experiences, struggles and successes. Interviews were first conducted with high-level administrators to provide an overview of the project and also to identify other staff members as possible interview candidates. Although the intention was to interview naturopathic doctors working in these settings, we were also inspired to learn from other providers and administrative personnel belonging to these IPCMH teams. At times, administrators recommended we speak with office personnel, data managers and other levels of management to better understand the intricacies involved in maintaining an IPCMH. In other instances, different types of providers, such as licensed acupuncturists, social workers, and dieticians, were also interviewed to provide insight into the collaborative relationships that exist in IPCMHs. Other types of providers, described in more detail below, are able to offer unique perspectives on the NDs' role in these settings.

Semi-structured interviews were conducted with staff and practitioners working within these selected clinics. Semi-structured interviews were favored for two reasons. Firstly, they diverge from a rigid line of inquiry and allow respondents to speak freely to share insights the interviewer may not have conceptualized or identified at the start of the project. Secondly, this process gives respondents a stake in the project as well as a voice to shape the direction of the research which often yields new and unintended discoveries. An interview protocol was developed around a framework of specific themes to explore related to the challenges, successes, and barriers associated with NDs working in an IPCMH. (A copy of the interview protocol is included in Appendix at the end of this document.)

[4] https://integrativehealth.org/examplesinpractice

At MVNM, a total of six providers including two naturopathic doctors, a dietician, a social worker, an integrative health coach, and an RN/panel manager were interviewed for this project. Interviews were conducted over the phone with staff and practitioners in the fall of 2015 and on average lasted between 30-60 minutes. In 2016, follow-up interviews were scheduled with selected respondents to gather more information or to clarify points that were previously discussed. Interviews for qualitative research purposes are normally recorded and transcribed for accuracy, but this process was not a possibility due to funding limitations. For record keeping purposes, detailed notes were captured in a blank interview form for each respondent at the time the interview occurred. Because detailed notes were taken to capture interview data, some of the quotes presented in this document were revised as needed to improve clarity and fluidity. Finally, to check the accuracy of the data and reporting, a copy of each clinic profile was sent to all respondents contributing to the project prior to dissemination to ensure accuracy. During this period, respondents had an opportunity to add, modify, or delete content.

Interview notes were reviewed multiple times to identify major themes and trends. As themes emerged, they were sorted into various topics which are described in more detail below. To benefit other clinics wishing to become a PCPCH or PCMH, lessons learned will be summarized at the end of each section.

CLINIC DESCRIPTION

This section provides a brief history of Mountain View Natural Medicine (MVNM) to better contextualize the range of services offered at the clinic. In addition to providing some background information on the creation of the clinic, this section also delves into the demographic characteristics of patients seen as well as the types of conditions commonly treated at MVNM. The last segment in this section explains how naturopathic medicine is naturally aligned with patient-centered and primary care and connects providers' behaviors to some of the tenets associated with integrative medicine in practice.

About Mountain View Natural Medicine

Mountain View Natural Medicine is a primary care clinic focusing on general medicine with individual providers who have expertise in certain areas including Gynocology, Pediatrics, and Cardiovascular and lung health. As its website explains[5], the clinic offers an extensive range of services including routine physicals, primary care screenings, gynecological and breast exams, natural bio-identical hormone replacement, the treatment of minor and moderate acute illness, the management of chronic diseases, nutritional counseling and weight management. MVNM treats an impressive array of conditions and issues such as thyroid and adrenal disorders, anxiety and depression, sleep problems, fatigue, digestive disorders, inflammatory conditions, auto-immune disorders, infections, detoxification, menopause, PMS, fertility, vaginal infections, cycle problems, breast and bladder health, sexual function, and fibroids. MVNM focuses on preventative strategies based on the unique needs of each patient and offers individualized wellness plans that incorporate stress reduction, diet, and appropriate use of supplements.

The clinic was established in 2010 by Dr. Lorilee Schoenbeck, ND, who was instrumental in leading the effort for naturopathic doctors to be recognized as primary care providers covered by insurance in the state of Vermont. Dr. Schoenbeck, well known for her expertise on women's and adult natural

[5] http://www.mountainviewnaturalmedicine.com/

medicine, is also an instructor at various educational institutions including Johnson State College, The Kripalu Center, and The Omega Institute. She also served as the president of the Vermont Association of Naturopathic Physicians and was the first naturopathic doctor to practice natural medicine in a gynecological clinic owned by Planned Parenthood. Given Dr. Schoenbeck's passion and dedication towards the professionalization and advancement of the field of naturopathic medicine, the decision to become a PCMH in 2013 was a pragmatic extension of her unwavering commitment and support.

The clinical team at Mountain View includes three naturopathic doctors, one naturopathic resident, and a registered dietician. Although these providers represent the core of this primary care practice, the Community Health Team expands services and supports doctors' treatment plans and includes a social worker, an acupuncturist, an integrative health coach, and a registered nurse/panel manager. Occasionally, a practice facilitator from Vermont Blueprint for Health works with the team to provide guidance on deciding which panels meet specific standards. The role of the practice facilitator as well as the importance of the community health team will be discussed in more detail elsewhere in this report.

MVNM is located within a larger health care complex, Eastern View Integrative Medicine, a building that houses a dozen practices offering services such as Ayurvedic consulting, chiropractic care, psychotherapy, biofeedback, acupuncture and post-natal support. Eastern View Integrative medicine is home to one of the state's largest OB-GYN clinics also, Maitri Health Care for Women, who deliver an average of 80 babies per month in nearby hospitals. The mission of Eastern View Integrative Medicine is to bring together providers from various backgrounds, disciplines and training to offer collaborative, comprehensive and holistic care because it is believed that, "by collaborating and working together, [they] can provide care that is exponentially better than if [they] worked alone[6]." The geographic proximity of providers at Eastern View Integrative Medicine facilitates collaboration, communication and referral across all practices, including MVNM.

Patient Care and Composition

As outlined in the preceding section MVNM is a full-service, naturopathically-led primary care clinic that offers "holistic, evidence-based natural medicine" to its patients[7]. While providing an overview of the clinic, one naturopathic doctor explained that MVNM is "focused on providing primary care from newborn stage on up [and is] part of a larger integrative medical model by our association with Eastern View Integrative Medicine." She added that about seventy-five percent of the patients seen visit the clinic for primary care.

Community health team members discussed the types of clients they routinely see at Mountain View as an extension of primary care. The integrative health coach talked about the demographic characteristics of clients she typically works with at Mountain View and gave details about how she supports patients on their journey towards self-care and discovery. She explained,

"Eighty percent are women and the majority tend to be between 20-50 years of age. A few are working with obesity or self-image issues, and many are going through a lot of transition in their life (college student going through stress of being away from home, or receiving a new medical diagnosis) and they are having difficulty managing it. [I am] starting to realize how much it affects people if they can't do the things they want to do… I help people step back to see the big picture and what life is all about. What [they] value. The biggest thing for me

[6] http://easternviewvt.com/

[7] http://www.mountainviewnaturalmedicine.com/

is having a non-judgmental ear. I say, yes, that's a lot going on - and I have found that not offering a solution usually helps people. It allows clients come to conclusions themselves."

MVNM has opted to serve their obese patients who are ready to adopt healthy changes as their most important way of impacting health care costs and people's lives in the long run. Another member of the Community Health Team, the registered dietician, shed some insight into the various types of patient conditions they treat at Mountain View. She added,

"The majority of cases I see are weight related. Weight always comes up. A lot of people are dealing with weight loss. Gastrointestinal (GI) issues are also huge - small intestinal bacterial overgrowth, FODMAP -- and GI dysfunction. Others have auto-immune dysfunctions as well and these practitioners seek out MVNM because they haven't had success with their other providers."

Overall, patients seen at MVNM are typically women between 20-50 years of age and receive treatment for a variety of conditions. This finding is not surprising given the fact that one of the doctors at the clinic specializes in women's health. During the surge in the popularity of integrative medicine in the late 1990s, it was reported that integrative therapies were primarily being utilized by those with high socioeconomic status in the same age categories[8] and this finding bolstered the erroneous belief that IHM is for the privileged and affluent. Today, MVNM and many community clinics throughout the US have demonstrated that integrative medicine and health clinics can be affordable and accessible to all because doctors at the clinic treat diverse and vulnerable patient populations. An upcoming section on Community Health Teams will expand on the concept of accessibility in more detail and will highlight how naturopathic doctors work in partnership with social workers and other team members to expand the delivery of services.

Naturopathic Medicine as Primary and Patient Centered Care

Naturopathic medicine is naturally aligned with patient-centered and primary care because it places patients at the center of care, it provides individualized approaches to treatment, and it uses non-invasive and preventative therapeutic methods. These core values, behaviors and practices are common to other integrative health professions including acupuncture and Oriental medicine, Chiropractic, Integrative Medicine, Massage Therapy, and Direct-Entry Midwifery. The principles of integrative medicine as a possible remedy to the economic burden associated with the management of chronic diseases in the US are examined in a 2009 article titled, *Integrative Medicine and Patient-Centered Care*. The authors outline the tenets of integrative medicine in practice, as shown in Table 2. below, and provide numerous examples how the integrative professions are innately oriented toward patient-centered and team-based care. The authors contend that these principles support therapeutic relationships and also signal a departure from a disease-based paradigm to one that is focused on health creation. Health promotion, they argue, is best supported by health oriented teams rather than ones that specialize in diseased states. As noted earlier in Table 1., the components of PCMHs are closely aligned with the values of integrative health and medicine because they represent a comprehensive, collaborative, team-based approach to care while also focusing on accessibility and coordinated services.

[8] Eisenberg et al.

Table 2. Tenets of Integrative Medicine in Practice [9]

Patient-Centered Care	Defined by providing custom treatment recommendations, taking into account patients' preferences and beliefs, spending time with patients, considering patient opinions, and encouraging patient engagement.
Patient Empowerment	Movement away from hierarchical provider-patient relationship and authoritarian approach toward healing in favor of one that fosters patient agency.
Communication	Belief that nonspecific influences including a positive prognosis, empathy, empowerment, connection, and education impact health.
Behavior Change	Recognizes that the therapeutic relationship based on meaningful and respectful interaction helps create positive behavior change.
Continuity of Care	Supports the healing process by creating a forum for dialogue and relationship building. With this trust, patients feel safe expressing the emotional and mental causes of illness. The continuity of care supports behavior change and adherence to treatment.

MVNM is an excellent example of this model in practice because it demonstrates beyond theoretical constructs that naturopathic medicine is well-suited for primary care within a medical home model. The director elaborated on these ideas by stating,

"Naturopathic medicine is, by definition, patient-centered primary care. Many of our patients use naturopathic doctors for their first-contact acute and chronic care as well as health screenings: Paps, well-child checks, cardiovascular screenings and management of most general health conditions for example. This is primary care. Our training as naturopaths has always put the patient at the center of their own care, as we choose treatment approaches individually tailored to a patient's unique situation, needs and goals. Therefore, operating as a Patient Centered Medical Home is a natural fit for us (See Table 1). In fact, to *not* recognize naturopathic primary care practices as medical homes omits patients who choose this style of health care from the umbrella of health reform.

Naturopathic medicine is an emerging player in the health care arena. All naturopathic doctors are trained to provide routine primary care services and serve as first contact for most chronic and minor acute problems common in general practice. Upon completion of their training, about half go on to expressly serve as primary care providers, with the other half serving a more specialist role to certain patient populations (such as integrative oncology or endocrinology) or specializing in one or more naturopathic modalities (such as homeopathy, nutrition or physical medicine). Those naturopathic doctors who provide primary care offer share many services in common with other primary care disciplines: mammograms and colonoscopies, immunizations and prescription meds, to name a few. These services are always applied within the philosophy of "first do no harm", "prevention" and "using the least invasive effective therapy" that naturopathic medicine espouses. If an herb will do it, great. If a diet change will accomplish the result, even better. But if a prescription is needed, that's what's appropriate. We're realists. We do what's best for our patients, and in keeping with their values. Most of them would prefer a natural approach, and to avoid invasive therapies when possible--who doesn't, actually? A naturopathic approach just makes sense."

Other providers shed insight as to how these core values are practiced and represented at MVNM. According to providers at MVNM, NDs counsel patients on diet and lifestyle thereby invoking preventative strategies. By building rapport and trust with patients through extended office visits,

[9] Adapted from *Integrative Medicine and Patient-Centered Care*

naturopathic doctors embrace patient-centered care and deepen therapeutic relationships with their patients. As the panel manager/RN explained,

"Naturopathic doctors are so knowledgeable about diets, supplements and natural remedies. I have learned so much [from them]. [It is] so impressive to see how much they care about patients who come through their doors. But also, naturopaths spend 45-60 minutes on everyone they see. Regular docs spend only 15 minutes and that simply leaves no time to speak with [patients] about diet."

The registered dietician commented on the amount of time doctors spend with their patients at MVNM and how it impacts care. She said,

"One of the biggest things I appreciate is that patients get to [experience] a good amount of time with their provider. Patients are heard. They have time to express their concerns. NDs spend a good amount time, and by that I mean, quality time with patients. NDs have 45 minute visits, which is remarkable. It gives a whole level of care to patients."

In addition to reflecting the values of integrative medicine, there is also the sense that participating in health care reform through PCMH membership bolsters the visibility of the profession. As one naturopathic shared, "Being in PCMH raises the perceptions of the profession - It makes us more of a player in the conventional medical model and elevates respect of the clinic because of what we are doing -- it is the same as what MDs are doing. "

To summarize, the core values of integrative health and medicine are innately oriented towards patient-centered and primary care. As an example of these principles in action, MVNM demonstrates that medical home model is a natural fit for naturopathic medicine. Other providers at MVNM observe on a daily basis the interactions and behaviors NDs engage in with their patients and highlight their commitment to the core values mentioned above.

PCMH STRUCTURE

This section provides insight into the structure, components, and organization of PCMHs and also explains how the state-led initiative, Vermont Blueprint for Health, provides operational support to clinics throughout the state. The inspiration and motivation for becoming a PCMH is also explored in this section along with the usual trials and tribulations associated with tracking and managing data. This section follows with a description of MVNM's community health team as an extension of primary care and how it addresses some of the social and cultural determinants of health by connecting patients to social and economic support services. Finally, the section concludes with providers discussing some of the benefits and challenges related to working in a PCMH environment.

Vermont Blueprint for Health

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities by providing operational support to PCMH clinics throughout the state[10]. Blueprint focuses on Triple Aim goals (reducing health care costs, improving population health and enhancing patient experience) and has successfully

[10] http://blueprintforhealth.vermont.gov/blueprint_101

implemented dozens of medical homes throughout the state. Although a full description of Blueprint is beyond the scope of this report, it is important to understand how PCMHs contribute to the organization's overall schema. The text box below provides an overview of the Blueprint's major activities.

Blueprint grants PCMH clinics access to a variety of useful materials including evaluations, annual reports, journal articles, legislative briefs, and community network analyses on the status of medical homes in Vermont through its website. Blueprint provides operational support by organizing meetings, events, and stakeholder groups and by providing access to a variety of implementation materials including performance based payments, care management toolkits, patient satisfaction surveys, and grant reporting templates. Beyond information, Blueprint provides some financial support in monthly payments for Community Health Teams, which will be discussed in more detail in an upcoming section. Even though Blueprint shares templates for tracking and collecting data on patient satisfaction, MVNM conducts their own satisfaction surveys in house. Results from MVNM patient satisfactions surveys are overwhelming positive and selected findings from a recent in-house study are included in the appendix of this report.

How Blueprint Works[11]

The Blueprint is a statewide initiative with local leadership and implementation
Community Collaboratives identify local health priorities, plan coordinated responses coordinated responses
Patient-Centered Medical Homes provide top-quality primary care
Community health teams extend available services
Extended Community Health Teams support addiction recovery through the Hub and Spoke Program
Performance payments fuel high quality, high value care
Measurement and analytics support a Learning Health System

Beyond granting access to materials and reports, Blueprint also mobilizes human resources though practice facilitators and community health teams, which are integral components of Blueprint's PCMH model. Practice facilitators work with clinics to help manage data, oversee quality improvement processes, and to provide guidance on initiatives leading towards continual improvement. Community health teams support primary care by broadening the availability of social and economic services for their clients, and are created locally with input from area hospitals and practices[12].

Becoming a PCMH

MVNM's decision to become a PCMH was largely inspired by the state's commitment to health care reform as reflected by Vermont's policy actions highlighted below (Table 3). These actions have largely shaped the state's current health care goals which are to improve quality, to lower costs, to expand access to health insurance coverage, and to improve the health of Vermont's residents[13]. The advent of Blueprint for Health, a state initiative to change the delivery and payment of primary care, introduced four main features central to its model: advanced primary care delivered through patient-centered medical homes, support services through the creation of community health teams, multi-insurer

[11] Adopted from the Vermont Blueprint for Health Annual Report, 2016

[12] *Vermont's blueprint for medical homes, community health teams, and better health at lower cost.*

[13] *Health Care Stewardship: A Vermont Case Study*

payment reforms, and continuous evaluation and improvement[14]. Because of these factors, MVNM's decision to become a PCMH was rooted in the desire to be part of the future of health care by participating in healthcare reform.

Table 3. Timeline of Vermont's Commitment to Health Care Reform

1990s	Governor Howard Dean promoted universal coverage
2000s	Health care reform was an ongoing political agenda
2002	Governor Douglas shifted focus to health care delivery
2006	Blueprint was created to improve chronic care management
2007	Blueprint expanded to focus on primary care & pilot PCMH model
2010	Blueprint office directed to expand the initiative incrementally over the next three years to include any practice interested in becoming a PCMH by 2013
2011-2012	Green Mountain Care Board & legislation supported universal coverage and payment and delivery reform
2013	Recipient of the Center for Medicare and Medicaid State Innovation Model

When asked why MVNM became a PCMH, the director explained,

"Well, it is simple. We want to be covered providers in the future, and the future is healthcare reform, and the future is NOW. Vermont is transitioning out of a fee for service model to more of a PCMH or ACO model, and if you are not one, than you will not be part of the health care system, certainly not as a primary care provider. We also wanted to demonstrate that naturopathic clinics can participate in health care reform and should be part of the mix moving forward. Any professions that miss out on joining the health care reform movement are relegating themselves to becoming a footnote in this history of medicine. I don't want it to happen to our profession again."

Another provider, an ND, expressed similar sentiments and offered a piece of advice for other clinics wishing to become a PCMH by stating,

"I guess the big question is, Is becoming a PCMH the wave of the future? We jumped on board because we believe that it is. If a clinic is willing to do the work, [they should do] it when you [they] have a smaller [patient] population. If you have to supply evidence and chart for 2000 patients, it is much more difficult than if you were charting for 200 patients. There is a large learning curve for new graduates, but it is something that will pay off in the end."

The reform initiatives launched by legislators helped forge a tradition of health care stewardship that is palpable throughout the state of Vermont. Naturopathic doctors at MVNM support this cultural tradition as evidenced by how swiftly they have embraced the spirit of the PCMH model. The motto, "Better organization leads to better care," as the director explained, provides a purview into MVNMs organizational philosophy. Put another way, "The PCMH structure is very similar to naturopathic medicine and has only made us more organized," she explained. While the structure of the PCMH model as it relates to naturopathic medicine will be discussed in an upcoming section, it is important to point out that providers at MVNM support the notion that the manner in which a clinic is organized impacts care. It is difficult to assess how quickly MVNM transitioned to a PCMH model, yet adopting this philosophy undoubtedly produced a shared mindset among providers, or at the very least, created the framework or expectation for reform.

[14] https://www.pcpcc.org/initiatives/vermont

From MVNM's perspective, there are two aspects to becoming a PCMH: delivering care and proving it. As the director explained,

"There are two aspects of becoming a PCMH. The first is delivering care and we have no problem doing this - we ask patients their goals, we overcome barriers to care and we focus on participation. All of these are embedded in the PCMH requirement. The second is the difficult part, proving it - tracking patients, documentation, follow-up procedures. We rely on staff to bring patients in for treatments."

MVNM reduced some of the burden associated with transitioning to a PCMH clinic by educating patients about how health care would be transformed under the new model of care. The process of becoming a PCMH also meant changing patients' perspectives and expectations and the clinic explained to existing patients that they would "continue to enjoy the personalized whole-person [approach to] care, but with an added focus on patient-partnership to prevent and treat health issues[15]." As part of its commitment to patient education and engagement, MVNM outlined what patients could expect as a result of the PCMH structure. They highlighted new features on the MVNM website such as ongoing contact about visits and screenings, additional support services, and improved coordinated care in regard to referrals, medications, supplements, imaging, labs and hospitalizations.

Tracking and managing data is a common challenge for most clinics transitioning to a PCMH model, yet MVNM addressed this challenge directly by recognizing that it is a necessary component of quality care. As the clinic director explained, "Dealing with data is a highly administrative burden and requires about 15-20 hours per week to deal with the [associated] responsibilities. It is a cultural shift for naturopathic doctors to be more organized in their care." By adopting the motto, better organization leads to better care, MVNM created an internal culture that embraces quality improvement initiatives since the arduous task of managing data has been positioned as another tool to patient improve care. Still, even with this understanding, providers at MVNM shared some observations about their experience with electronic health record systems (EHRs) in regard to personal habits, cost-effectiveness, and recording doctors' notes on patients.

As noted in other ACIH profiles on IPCMHs, the development of effective data management techniques often involves a steep learning curve, and at times, the incorporation of these new techniques produces additional obstacles for clinics to overcome. These obstacles may challenge the value providers place on authentic human connection over the use of technology for efficiency. In the case of MVNM, adjusting from paper to electronic charting was not necessarily difficult, but it did impact how one doctor related to her patients. A naturopathic doctor explained,

"When I was in California, I did paper charting and moving [to MVNM] it turned into e- charting. There are good and bad aspects with e-charting. I notice that I remember people's names less [than I did before] because with paper charting, you are writing patients' names over and over again. These are people you see repeatedly and eventually you learn their names by writing them. I didn't realize that was going to happen. Also with e-charting, you have to be a lot more methodical when you bill insurance as compared to when you are not billing insurance."

Another ND talked about the cost-saving advantages of having a good (EHR). She said,

"If you are large or medium sized clinic, it becomes very helpful to have a robust EHR that does tracking for you. Some EHRs have robust reporting systems that help you meet PCMH standards which [has the capability of] pooling all patients who haven't come in for care that year. We have to do [that process] by hand. We would be

[15] http://www.mountainviewnaturalmedicine.com/index.html

saving money if we had a robust EHR...We [also] have to adapt our reporting methods. And in some cases, we create excel spreadsheets by hand to follow PCMH measures that are not part of our health records since Practice Fusion[16] doesn't have a module for that. We also don't have an EHR that has integrated billing so we use two different systems for billing and medical reporting. I highly recommend an integrated one."

The panel manager/RN discussed how Mountain View addressed one of the limitations of their EHR by describing how they capture naturopathic specific data. She explained,

"One [of the EHRs] we are using is available free online. We [only] have a [small] budget [for EHRs] so we have to make it work. In one of the EHRs we use, the naturopathic doctors' document notes are pretty good. We have manipulated the system in such way to attend to how naturopathic doctors take patient notes."

In spite of the limitations involved with using EHRs, the panel manager/RN elaborated about how interaction with the EHR deepened her appreciation for the dedication and care naturopathic doctors have towards their patients.

"I do a lot of chart review [for many different types of practices]...In trying to obtain data, I have found that naturopathic doctors' notes are different from a regular medical doctor. They focus on the whole person. It is amazing to see how much time they spend with whole patient - they delve into diet and health and what makes [each person] happy. It is SO much different and really fascinating."

Overall, the decision to become a PCMH was inspired Vermont's history and commitment to health care and the desire to contribute health care reform. By welcoming the challenges associated with quality improvement, MVNM established a strong belief in the reform process. Similar to other IPCMH clinics, MVNM discovered that managing data can be a challenging endeavor, but the clinic's pioneering and resourceful attitude demonstrates a resilience in regard to the way responsibilities associated with data tracking and management are handled.

Community Health Teams

One of the signature features of Blueprint for Health's PCMH structure is the creation of Community Health Teams, which provide an essential link between primary care and community-based prevention of chronic diseases[17]. Community health teams serve as an extension of primary care because they provide services that support and reinforce treatment received during primary care visits. Examples of such services include health coaching, counseling, and individual care coordination. Community health teams address some of the social and cultural determinants of health by connecting patients to additional social and economic support services. The flexible structure of community health teams facilitates the inclusion of other integrative health professions. The clinic director explained,

"The other piece of PCMHs in Vermont is when a clinic receives PCMH status, they have access to community health team funding which is a very important part of medical homes. That is funding that is available and paid by insurance companies which allows clinics to provide support such as nutritional counseling, behavioral therapy, health coaching, and in our case, we have chosen acupuncture to augment primary care, which patients get for free. So, patients who we deem as benefitting from 4-6 acupuncture treatments for knee pain in order to exercise, they get that for free."

[16] Practice Fusion is a free EHR.
[17] Health Affairs

As the quote above demonstrates, community health teams provide additional support based on a clinic's unique needs. In this instance, MVNM incorporated acupuncture as part of its community health team model to offer more robust care to their patients. As noted in a previous section, the community health team at MVNM includes dieticians, health coaches, nurses, and social workers that all play an integral role in addressing health care disparities while supporting doctors' treatment plans. The inclusion of social workers allows naturopathic doctors to better attend to needs of specific patient populations, and further enhances whole person care. In this sense, social workers augment primary care by connecting patients to services that support their well-being while simultaneously reducing barriers to care. A naturopathic doctor explained,

"Naturopathic doctors really don't know how to use a social worker and we are still learning how to use ours. Historically, naturopathic patients have been educated, high-income individuals and haven't had the need for transportation assistance, food relief, housing, and drug & alcohol counseling that conventional primary care docs contend with [on a regular basis]. But, as we move towards greater accessibility, mainstream problems come with it. Our Medicaid population for example, and uninsured population, often need help just getting food on the table. So these are typically not areas where naturopathic doctors have training and [having social workers on our team allows us] to connect patients to community resources."

Another naturopathic doctor explained how the inclusion of social workers enables doctors at MVNM to focus exclusively their specialty by saying,

"...Patients can't afford naturopathic doctors. It has been interesting to me to integrate social workers into practice. We always thought we were doing social work, but as we become more involved in treating Medicaid and other vulnerable populations, we are [seeing] people who have violence and drug addiction and very severe abuse. These are very intense populations that need social workers who are plugged into other networks. It's been an interesting cultural and educational process bringing in a team that has specialized expertise in the care our patients need that allows us to do what we do best – identifying treatment plans and [working with] other providers who help execute that plan."

The social worker at MVNM expanded on this idea and alluded to the idea that social work is needed both to support the continuity of care and to enhance patient experience. From a practical standpoint, although naturopathic doctors support whole person care through extended office visits, delving into matters pertaining to housing assistance, food relief, addiction, etc. goes beyond a typical office visit. She explained,

"...the longer we are doing this, one of the needs that has really come to the top is social work. Naturopathic doctors' time is limited and we have the luxury of time. Because we don't bill per hour, we can stick with complicated patients to figure out the client's situation and how to get them back to see the doctors.

Additionally, community health team members play a vital role in supporting treatment plans designed by naturopathic doctors. As MVNM's nutritionist explained,

"I appreciate working with NDs because they recognize and value diet. It is the one thing we are exposed to every day and I respect that....I was approached by Mountain View because they didn't have time to time to educate patients to work on diets they were prescribing. I provide support to clients for recommended diets. Diet change can be stressful and overwhelming for patients. We, as nutritionists, have more time. We do individualize meal planning and help them figure out what works for them given the amount of time they have as well as their budget. We also take them on shopping trips."

The inclusion of social workers as part of the PCMH Community Health Team at Mountain View bolsters patient compliance while minimizing some of the barriers associated with care. Social work services

improve issues related to food insecurity and promote access to other services that naturopathic doctors recommend to patients. As one naturopathic doctor stated,

"It [social work] provides some backup for us if we have a patient who cannot afford to comply with our dietary recommendations or cannot afford a gym membership if someone needs to exercise. Social workers can connect them to free services. Even after two years we haven't filled [our social worker's] schedule. As naturopathic doctors, we feel we can do it all. We are still learning. Our social worker is a resource and we are learning how to reach those communities."

By and large, community health teams function to provide indirect and direct support to improve patient care as part of the PCMH model in Vermont. Given the context and unique needs at MVNM, acupuncturists, integrative health coaches, nutritionists and social workers were specially selected to augment and extend naturopathic care. The incorporation of these team members enables Mountain View to focus on community health needs by reducing some of the barriers associated with care. The community health team at Mountain View also reinforces naturopathic doctors' treatment plans while enhancing the patient experience across the care continuum.

Advantages & Challenges of Working in a PCMH Environment

Throughout the interview process, providers were asked to pinpoint the successes and challenges associated with working in a medical home. As stated previously in this report, one of the primary advantages of adopting a PCMH structure is the inclusion of naturopathic medicine within mainstream medicine. As one ND articulated, "If anybody ever questions if NDs are real docs or primary care docs, nothing says primary care like a medical home. Once they mention they work in a PCMH, that literally silences any questions or doubts that anyone else in the medical establishment has about whether or not they are primary care providers".

Beyond the advancement the profession, another success associated with medical home membership is the satisfaction knowing that patients are receiving superb care. The nutritionist expressed,

"I think being able to see people who have tried every other avenue and are now finally seeing results and feeling better. That alone makes it worth coming to work. People have been working with digestive issues for years and to see them heal, is so rewarding. And the camaraderie! NDs see me in the hall and tell me what a good job I am doing and it is so rewarding and uplifting. If I were in my clinic, I wouldn't have that experience."

For many providers, it was difficult to identify challenges mostly because Mountain View appears to have excellent communication channels in place to address concerns before they morph into complicated issues. When pressed for a challenge, the nutritionist explained how working in an interdisciplinary fashion has the potential to create different treatment outcomes for patients, and could create confusion for patients. Ongoing dialogue and communication reduce the likelihood of this possibility. She added,

"I think sometimes our scopes of practice overlap and it just a matter of how we maintain balance. We worked out a good system at our practice. Dieticians can recommend supplements and order labs, and so we have a lot of open communication among providers. If I think a patient should be on a diet, we do a really good job of keeping communication channels open. We didn't want anyone to think we were giving recommendations that went against what NDs recommended to their patients. NDs are really receptive to recommendations we suggest and they provide justifications for either a yes or a no [for our recommendations]. But that could be a huge challenge."

There are often a lot of conflicting thoughts and ideas so we talk about research and why we are recommending what we are recommending."

She later stated that regular communication among providers has the ability to impact patient experience. To minimize the potential for confusion, providers are diligent about offering care that does not conflict with another provider's recommendations. She said,

"Initially, most patients see the NDs first anyways [before they see a dietician]. They already have a list of supplements. We [the dieticians] decided that we wouldn't make any recommendations right away. The first recommendations are generally things that NDs recommend. If it is something else that is different than what NDs recommend, I talk with the NDs first before recommending it. I try to streamline recommendations appropriately so they are not confusing patients."

When asked about challenges associated with working in a PCMH environment one naturopathic doctor touched on the importance of patient satisfaction and highlighted how data and metrics impact patient experience. She explained, the challenge for [me] is, "Finding diagnoses we are tracking that benefit patients without burdening them. Sometimes things are relevant to a person, but because I put diagnosis on a person, we have to jump through specific hoops. The challenges are simply the extra time need for charting and doing action plans."

The social worker talked about the challenges associated with having her services accessible only on a part-time basis. She explained,

"[My challenge is a] lack of time. Because we [social workers] are not present in the practice all of the time, it is hard to be in the forefront in NDs minds as a resource. Another facet of this challenge is changing the mindset about making referrals to us. Not being seeing on a daily basis makes it difficult because we are not embedded in the practice to offer our services."

The issue of time and the challenge associated with managing panels while juggling other responsibilities was described by another provider. The Community Health Team nurse/panel manager stated,

"It has been challenging to keep panel managers. I am there 6 hours a week, which is not enough at all. Twelve is better, maybe up to 20 hours because it is hard to complete one panel over a few weeks time since I see patients and have other priorities and responsibilities I need to tend to (medication management, diabetes education, etc.) and for some other MDs I call discharged patients from hospitals and nursing homes because that also satisfies a standard.

Overall, providers at Mountain View Natural Medicine identified a few challenges related to working in a PCMH environment. Although some challenges do exist related to patient burden, panel management, and provider accessibility, they do not seem to impede Mountain View's progress in any way. Providers are keenly aware of how they have the ability to impact patient experience, and the clinic proves to be quite adept at troubleshooting problems through ongoing communication and collaboration. Seeing positive patient outcomes and the field of naturopathic medicine being more accepted in mainstream medicine are two of the successful components related to working in a primary care environment within a PCMH.

CONTINUAL IMPROVEMENT

The last section explores aspects of continual improvement by describing administrative processes and communication practices related to population health management. The section on quality measures provides insight into the MVMN's strategy for selected measures and showcases how it is possible to implement care that is consistent with naturopathic values within a PCMH environment.

Panels and Population Health

Quality improvement initiatives are central to the primary care medical home model and encompass four main areas: performance management, using evidence-based medicine to guide shared decision making processes, monitoring patient experience and satisfaction, and population health management (See Table 1.). Managing data for population health, often referred to as running panels, may also be viewed as a team-based endeavor since it involves much collaboration among providers. In order to meet and sustain quality and safety components as stipulated by PCMH accrediting agencies, clinics must identify groups of patients with specific conditions and must also provide a plan for how to manage care for these specific groups. Administrative tasks and processes are part of population health management and contribute to transparency, reflection, accountability and action. Adding this extra layer of administrative tasks is extremely time consuming, but by doing this work, MVNM discovered that some of these processes not only help doctors' assess progress with patients, but they also motivate doctors to improve outcomes when they are compared to their peers. One naturopathic doctor explained,

"It was motivating for [me] to see that another doctor is treating [a high percentage of her patients with depression than me]... Overall, I find it really motivating [to review those figures], but the end product took a significant amount of time to generate...Once a month we get together for a check in and it [the meeting] always has some PCMH element and covers items like signing forms or how to do certain procedures."

Analyzing patient data and then sharing it with providers promotes transparency and accountability through individual and collective reflection. One naturopathic doctor explained, "We have meetings every 6 months, and all five doctors are given spreadsheets on performance for who I am tracking for 3 measures, the associated action plan, and how to collect proper documentation." The routine practice of disseminating clinic data helps providers understand how the clinic is functioning overall and enables each provider to gauge how s/he is contributing to success. Blueprint lends some added support to MVNM by overseeing panel meetings and by creating learning communities through panel manager retreats. Additionally, practice facilitators provide guidance to clinics and help them decide which panels meet specific standards. The panel manager at MVNM described this team approach to panel management by saying,

"[The medical director] and I work with the Project Facilitator from Blue Print to satisfy standards. We have huddles to decide how to proceed. We compile lists of patients with similar conditions, for example diabetic patients and the labs that they need. We recently did a report on dyslipidemia patients to see if they had tests run. It could be patients age three who did not have a wellness exam yet for the year or patients who have not had tetanus shots."

In sum, population health management seems to be an extension of the collaborative and team-based spirit of the PCMH model at MVNM. MVNM partners with a Practice Facilitator from Blueprint to run the appropriate data needed monitor the clinic's progress towards meeting its selected measures. By

regularly sharing provider data, the clinic fosters a learning culture centered on transparency and collegiality. Lastly, providers at MVNM work individually and collectively towards continual improvement efforts.

Quality Measures

To achieve and ultimately maintain PCMH status, clinics are required to meet standards outlined by accrediting agencies, such the National Committee for Quality Assurance (NCQA) or the Accreditation Association of Ambulatory Health Care (AAAHC). Once a clinic becomes a PCMH, it is required to maintain a set of standards focusing on accessibility, team-based care, care management and support, care coordination, population health, and quality improvement (Table 4). Although clinics are required to provide data on specific measures, they do have some flexibility and choice in regard to selecting what measures they want to track. MVNM achieved its PCMH status through NCQA and initially selected a blend of conventional and non-conventional measures for preventative initiatives that included mammograms, colonoscopy screenings, and vaccinations[18]. Eventually, the clinic decided to focus on vaccinations instead of annual nutrition visits due to challenges associated with patient compliance.

Table 4. Standards for Becoming a PCMH, NCQA[19]

Patient-Centered Access	Accommodate patients' needs during and after hours, provide medical home information, offer team-based care.
Team-based Care	Engage all practice team members by providing medical home information, meet cultural and linguistic needs of patients and offer team-based care
Population Health Management	Collect and use data for population management
Care Management and Support	Use evidence-based guidelines for preventative, acute and chronic care management
Care Coordination and Care Transitions	Track and coordinate tests, referrals, and care transitions
Performance Management and Quality Improvement	Use performance and experience data for continuous improvement

One of the common misconceptions about naturopathic doctors working in a PCMH environment is that they do not have the authority to implement interventions consistent with their values, and must instead follow prescribed treatment plans. Contrary to this, through their selection of clinical care management measures, MVNM shows that the PCMH structure supports naturopathic doctors' decisions to implement care that is consistent with their values. Table 5. below provides an example of the three conditions MVNM selected to track and the corresponding naturopathic strategies they use to manage patient care. The clinic director explained,

"We had to select 3 conditions to track for clinic care management so patients would avoid developing complications. I want to talk about that a little. We selected obesity, anxiety, and dyslipidemia (high cholesterol) and we had to identify

[18] For more information, see *Lorilee Schoenbeck, ND: Prevention and Quality Improvement in a Naturopathic PCMH in Vermont* (Part 2)

[19] https://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf

all primary care patients with those diagnoses and had to agree as a clinic how to treat conditions using an evidence based protocol. You have to have some studies to verify the approach you are going to use. For high cholesterol – we chose lifestyle and diet interventions primarily then if needed lipid lowering herbs (red yeast rice and GUGUL). If patients didn't respond then we moved to other means, medications. We were free to use any natural recommendation and if it didn't work then we refer or provide higher level intervention."

Table 5. Examples of Naturopathic Strategies for Specific Conditions within PCMH Environment

Obesity	*Dyslipidemia*	*Depression*
Tracking food (Smart Tracker)	Assess lipid levels, thyroid function, hemoglobin A1C	Standardized tool: PHQ 9
Exercise (Fitbit)	Annual visit	Supplements: fish oil, St. John's Wort, Vitamin D
Follow-up & Accountability	Return visits every 3 months If condition is not improving	Behavioral: Yoga, MBSR, life-style management
	Recommend lipid lowering herbs	
	Utilize community health team	

As the example above demonstrates, using an evidenced-based approach, naturopathic doctors are free to use whatever treatments they deem appropriate for patient care. The structure of the PCMH model supports naturopathic strategies for managing patient populations, and this approach also allows NDs to utilize some pharmaceuticals such as antibiotics, if naturopathic approaches were not successful.

CONCLUSION

In context of the changing health care landscape, the integrative professions are playing a pivotal role in reducing health care costs and enhancing patient experience through their involvement in PCMHs and PCPCHs. The PCMH and PCPCH models are improving health care by restructuring how primary care is organized and delivered. We are grateful for Mountain View's vital contributions to this report since health care providers are looking to the leaders of integrative medicine to provide information on how to successfully create integrative PCMHs. By exploring the early adopters, we can identify the best practices, strengths and weaknesses of these models, and share this knowledge with others to advance the integrative professions.

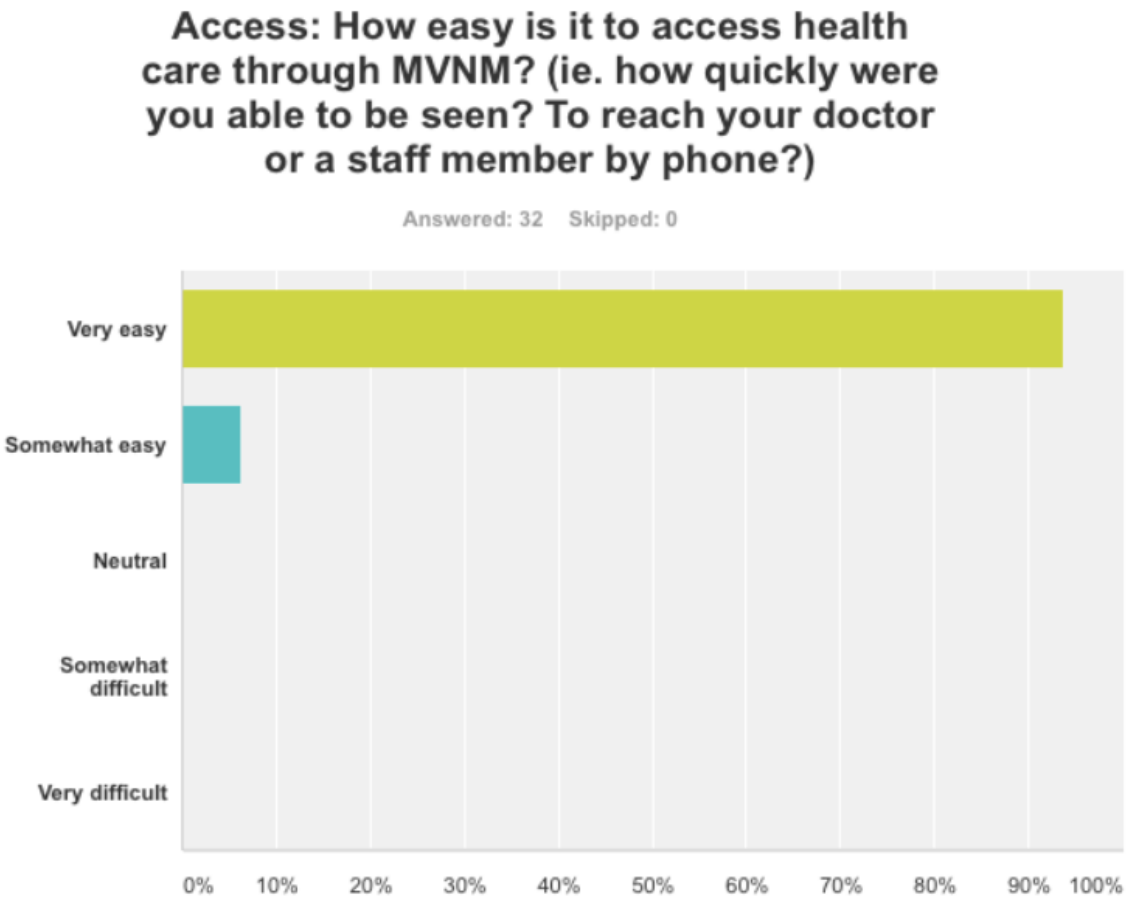
The induction of naturopathic doctors as leaders of PCMHs is an immense achievement for the profession of naturopathic medicine. Historically, the state of Vermont has embraced naturopathic medicine, and as a result of this openness, acceptance and inclusion, naturopathic doctors not only have the capacity to serve as primary care providers, but they are granted the ability to function as leaders of medical homes as well. The PCMH model has also created more opportunities for other integrative providers, such as chiropractors and acupuncturists; and some of these disciplines have been incorporated into Medicaid services. The fact that naturopathic medicine is delivering quality care using a new model of medicine demonstrates the profession's innate capacity for further inclusion at a much broader level. With the current policies in place that support integrative health care through the State

of Vermont, it is indeed an auspicious time for the field of naturopathic medicine to further advance the profession by assuming more roles in primary care.

Appendix A
Interview Protocol

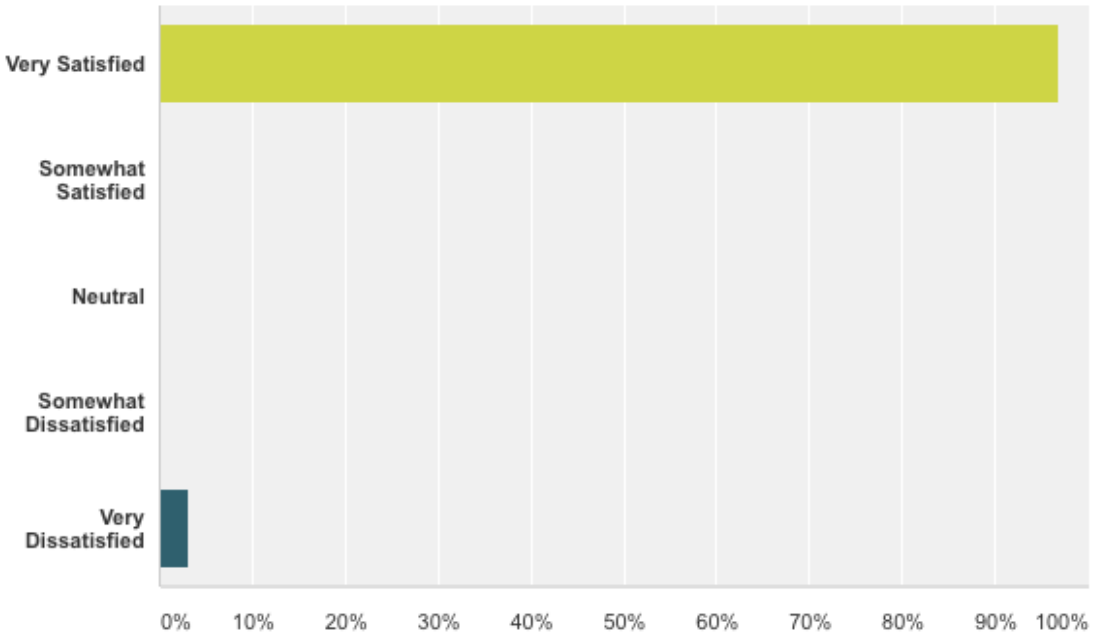
- About me and project overview.
- Tell me about your clinic. How long have you worked there?
- Does your clinic have a special focus? (teaching, underserved focus, population health)
- What kind of patients do you routinely see and treat at the clinic?
- What role does integration play in your clinic? What are the practices around sharing patients, referrals, collaborating with others, etc.
- Tell me about using technology in this new environment? Was it a barrier to overcome? EHRs?
- How does your clinic promote and build a culture of data and accountability?
- What do you identify as the biggest challenges related to working in a PCMH/PCPCH environment?
- What do you identify as the biggest successes related to working in a PCMH/PCPCH?
- Do you feel that participating in a PCMH has changed your profession or discipline in any way? If so, how?
- What kind of quality measures does your clinic focus on?
- Do you have any reports or data that shows patient outcomes? Other metrics? Patient satisfaction surveys?
- What kind of training would you recommend for students or graduates that might wind up working in a PCMH someday?
- Is there anything else I should know about that I did ask?

Appendix B
Patient Satisfaction Slides from internal MVNM study



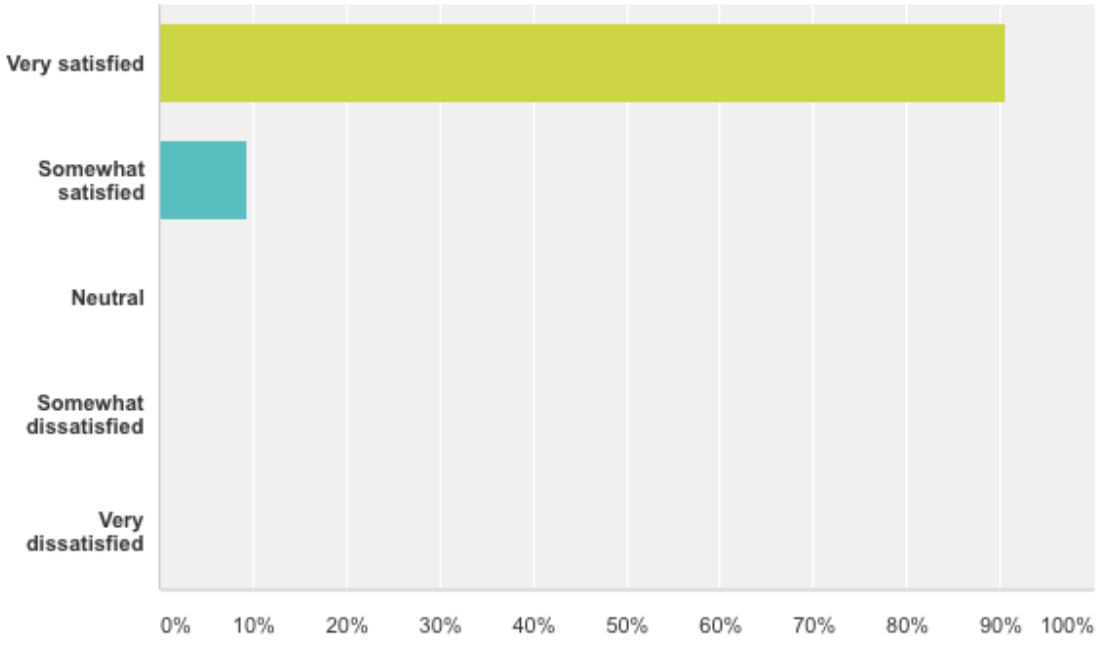
Wholistic support: How complete or holistically is your health care treated at MVNM? (ie. addressing mental, emotions, physical and spiritual well-being?)

Answered: 32 Skipped: 0



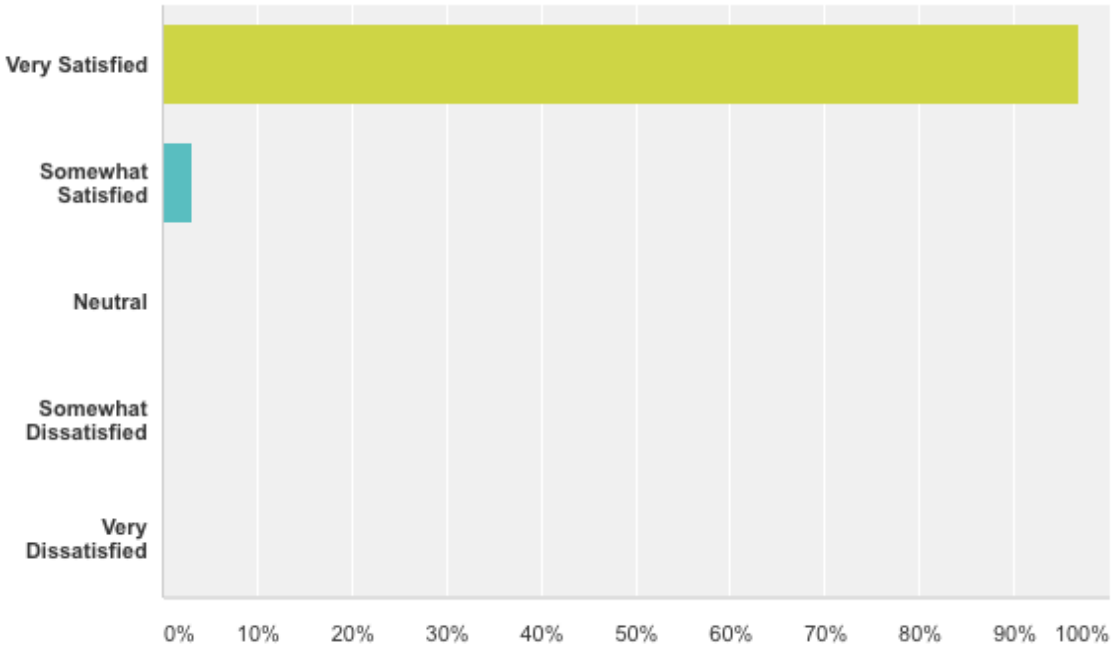
Communcation: How satisfied do you feel with how you were respected, listened to and able to get answers to your questions at MVNM?

Answered: 32 Skipped: 0



Coordiation of Care: How well do you feel MVNM helps you coordinate care you receive elsewhere (such as specialists and other providers as well as to community resources like classes?)

Answered: 32 Skipped: 0



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