Report to the Legislature on the Washington Patient-Centered Medical Home Collaborative

February 2010

Washington State Department of Health

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Background

In 2008, the Washington State Legislature passed Engrossed Second Substitute House Bill 2549. The bill directed the Department of Health to develop a medical home learning collaborative to promote adoption of medical homes in a variety of primary care practice settings. It also requires the agency to provide an annual report.

A medical home is an approach to providing comprehensive primary care for children, youth, and adults. This is done in a health care setting that makes it easier for patients and their families to communicate with their providers. The goal of this improved communication is better patient care and outcomes.

The legislation requires the department to report on:

- The rate of adoption of medical home in Washington.
- Best practices and how outcomes have changed.
- An assessment of how the pilots improve primary care provider satisfaction and retention.
- Any additional legislative action that would promote further medical home adoption in primary care settings.

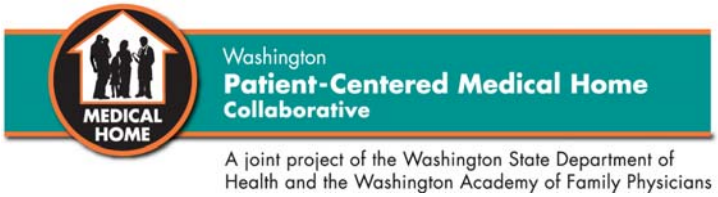
Rate of Adoption in Washington

The 2009-2011 biennial budget did not provide state general funds to support the Medical Home Collaborative. However, the department obtained in-kind and alternative funding to carry out our plan to train primary care providers. The funding amount only allowed the Medical Home Collaborative to continue on a smaller scale. Appendix A shows the programs and partners, and the support they provide.

Since 1999, the department has offered training for primary care providers using the collaborative methodology. Don Berwick, M.D., president of the Institute for Healthcare Improvement developed collaborative learning. It is a proven method to change health care processes and outcomes. It requires health care teams -- the people associated with the medical practice -- to share their successes and failures to move toward sustained change. The department provided six successful collaboratives based on the Chronic Care Model and focused on improving the management of a specific disease. Building on the Chronic Care Model structure, national medical home initiatives developed key changes a practice needs to make to become a medical home. The Patient-Centered Medical Home Collaborative teaches these eight elements of a medical home: engaged leadership, quality improvement strategy, patient centered interactions, organized evidenced-based care, continuous and team-based healing relationships, enhanced access, population management, and care coordination. The training package includes:

- The changes a clinical practice needs to make to be a patient-centered medical home.
- The pilot population the practice will focus these changes on.
- The data needed to measure changes in the practice.

Because their goals complemented those of the department's collaborative, the Washington Academy of Family Physicians merged their "Improving Performance in Practice" initiative with our Medical Home Collaborative. The academy's Robert Wood Johnson Foundation funding requires medical home concepts be spread to 30 practices in 2009 and 80 practices in 2010. The merger with the department's collaborative meant the academy could train the required number of practices. At the same time, the department could proceed with its collaborative work. The academy provided funding for some of the practice coaches support for collaborative learning sessions and funding for a medical director. Most importantly, primary care providers saw a strong union of two programs dedicated to helping them become a medical home. The following branding logo appears on all collaborative materials:



The department completed the work outlined in the work plan (Appendix B) on time. Collaborative enrollment opened on March 31, 2009. More than 35 practices asking to be enrolled. We created selection criteria and a scoring grid. A multi-organizational team met in June to select the teams. The collaborative launched on July 1, 2009 with the enrollment of 33 primary care practices from across the state. Coaches assigned to each practice conducted site visits during July, August, and September. Pre-work handbooks informed practices on the scope of the two-year collaborative.

On September 28-29, 2009, the first of five Learning Sessions was held for over 250 people representing the 33 primary care practices. The curriculum focused on an introduction to the national medical home concepts, measuring practice outcomes, team building, and developing action plans for the next six months. The clinical practices began sending written progress reports in November. They will send monthly reports until the end of the collaborative in September 2011.

The next Learning Session is scheduled for March 29-30, 2010. During this six-month period, monthly "webinar" conference calls will keep the teams engaged in learning. We will keep teams engaged using a monthly newsletter, phone calls from coaches assigned to each team, and a site visit from their coach.

Because of their enrollment in the collaborative, ten of the 33 enrolled practices received grants for health information technology from the Health Care Authority and First Choice Health Network. Additionally, we received a $25,000 grant from the Aetna Foundation to address Health Literacy. That topic will be incorporated into the medical home curriculum.

We can not determine with certainty how many primary care practices have adopted the medical home in relation to the total number of primary care practices in the state. We know that many more insurers and providers are focusing on the medical home model. For example, Group Health Cooperative created a medical home pilot at its Factoria clinic. After proving it improves care and provider satisfaction and reduces inappropriate emergency room use, Group Health plans to expand to all 26 medical centers.

The Boeing Company completed a successful medical home pilot in 2009. The pilot enrolled 740 eligible non-Medicare Boeing patients being treated by physicians at the Everett Clinic**,** Valley Medical Center, and Virginia Mason Medical Center clinics.

The Virginia Mason Winslow Clinic on Bainbridge Island in Kitsap County participated as one of 36 pilot sites nationally in the TransforMED medical home practice redesign project.

Many pediatric practices are adopting the medical home model. For almost 20 years, the department's office of Maternal and Child Health has helped develop a medical home in pediatric practices serving children with special health care needs. As of 2009, there are 21 pediatric practices supported by the Medical Home Network. This network connects practices to resources in their community to support the intensive care needs of children with chronic severe health issues. More information on these initiatives is available on our website: www.medicalhome.org/about/medhomeplan.cfm.

Best Practices: How outcomes have changed and how pilots improve primary care provider satisfaction and retention.

Our evaluation of Medical Home implementation is designed to answer the following questions.

To what extent have enrolled practices adopted medical home?
Each enrolled practice will complete a nationally approved assessment called the "Medical Home Index." This assessment will determine the extent to which the practice has adopted the elements of a medical home. he assessment was completed at the first Learning Session in September 2009, and will be given again in September 2010 and at the close of the collaborative in September 2011.

How has the patient experience changed?
A provider practice operating as a medical home uses patient-centered care techniques not routinely used by care providers. The impact of this shift in the focus of care asked in question two will be measured by a patient experience survey. This survey will be sent to 100 randomly chosen patients from each of the 33 practices in March 2010.

Are there changes in provider and staff satisfaction?
We answer this question by conducting provider and staff satisfaction surveys. These were given to the practices attending the September Learning Session to provide baseline data. Surveys will be collected regularly as the collaborative progresses. Since other national medical home projects resulted in significant improvements in job satisfaction, we anticipate providers and staff satisfaction will improve over the course of the two-year collaborative.

What impact does medical home have on quality of care?
We are measuring changes in care of people with diabetes enrolled in the collaborative. Beginning in February 2010, data will be submitted on blood sugar, blood pressure, cholesterol, smoking cessation, foot care, eye care, and kidney assessment. In addition, we will collect several prevention quality measures to determine changes in well child visits, cancer screening, smoking cessation, medications taken, and completing advanced directives. Monthly narrative reports capture the practice changes. Face-to-face meetings throughout the two-year collaborative process showcase the best practices found in these reports. Presentations made as part of the training on changes that work promote rapid adoption by other office systems.

Does medical home have an effect on health care use and cost?
We are seeking funding to work with researchers at the University of Washington to evaluate this question. The Primary Care Medical Home Reimbursement Model Pilot is an initiative convened by the Washington State Health Care Authority, Washington Department of Social and Health Services, and the Puget Sound Health Alliance. This pilot seeks to measure the impact of a medical home on health care use and cost. It will also examine how effectively one or more health care reimbursement models can align the incentives of primary care providers and payees to transform medical practices in a way that increases clinical quality and improves the patient's and practitioner's experience. We participate in a workgroup making recommendations to the reimbursement pilot on priority outcomes and essential skills a practice needs to be a medical home. These align with what we are teaching the practices enrolled in the collaborative. The workgroup also recommended that the collaborative practices be considered as pilot practices to test the new reimbursement model.

Does the collaborative have an effect on retaining the primary care workforce?
We are unable to directly assess whether the collaborative has an effect on retaining the primary care workforce. However, ongoing research informs our process and training. A list of resources is included as Appendix C. For example, Group Health Research Institute compared 9,200 patients at their Factoria Clinic to a control group. The evaluation demonstrated significant improvements in patients' and providers' experiences and in the quality of clinical care. Each primary care doctor (family physician or general internist) was responsible for fewer patients -- 1,800 instead of 2,300. After one year, only 10 percent of the medical home doctors, nurses, and staff felt "burned out" or emotionally exhausted. On the other hand, 30 percent in the control group felt that way. Despite the significant monetary investment in the redesign, the costs were recouped within the first year. A just-completed pilot project sponsored by the Boeing Company shows that enhancing care via a "medical home" designed explicitly for patients with severe chronic disease can improve quality of care and reduce per capita spending. Although it was a small study, the pilot project's findings align with other recently reported results from similar initiatives.

Any additional legislative action that would promote further medical home adoption in primary care settings.

Sustainable adoption of a medical home requires redesign of the reimbursement for primary care. The current payment system does not provide reimbursement for changing to a medical home model. A new system should provide payments to providers for making changes to their

practices based on medical home principles. Therefore, The Department of Health recommends the following:

- The primary care clinical practices enrolled in the Medical Home Collaborative should be given the option to participate in the pilot test of a new payment system for primary care providers.
- When resources become available, expand the evaluation design to capture the effects of a medical home on health care costs and emergency room and hospital utilization.

Many health insurers have committed to help the state test the Primary Care Medical Home Reimbursement Pilot model**.** These insurers include: Premera, Regence, Aetna, Cigna, Community Health Plan of Washington, Group Health Cooperative, Molina, and United Healthcare. The Health Care Authority, the Department of Social and Health Services, and Puget Sound Health Alliance are coordinating the group which includes representatives of health plans, business, unions, professional associations, and the Washington Academy of Family Physicians.

APPENDIX A

Washington Patient Centered Medical Home Collaborative Partners

APPENDIX A: Patient Centered Medical Home Collaborative Partners

Department of Health Program	Support
Diabetes	$50,000 and .7 FTE
Heart Disease	$29,500 and .5 FTE
Cancer	$20,000 and .1 FTE
Tobacco	$50,000 and .1 FTE
Asthma	$10,000 and .1 FTE
Rural Health	$30,500 and 1 FTE
Maternal Child Health	.2 FTE
Chronic Disease Prevention Unit	.4 FTE

External Partners	Support
Washington Academy of Family Physicians	$150,000 plus medical consultation, marketing, practice coaching
Health Care Authority First Choice Health	$135,900 in grants for health information technology
Seven Washington health plans[1]	$140,000 for practice support to attend learning sessions
Qualis Health	Faculty, webinar technology, conference room for meetings
Group Health Cooperative	Faculty
University of Washington	Faculty
Aetna Foundation	$25,000 low literacy grant
Department of Social and Health Services	Contract requirement that health plans support the collaborative
Academy Health & Commonwealth Foundation	Technical assistance
Puget Sound Health Alliance	Technical assistance

[1] Community Health Plan, Molina Healthcare of Washington, Group Health Cooperative, Regence Blue Shield, Columbia United Providers, Kaiser Foundation Health Plan, Asuris NW Health

APPENDIX B

Washington Patient-Centered Medical Home Survey and Learning Congress Timeline

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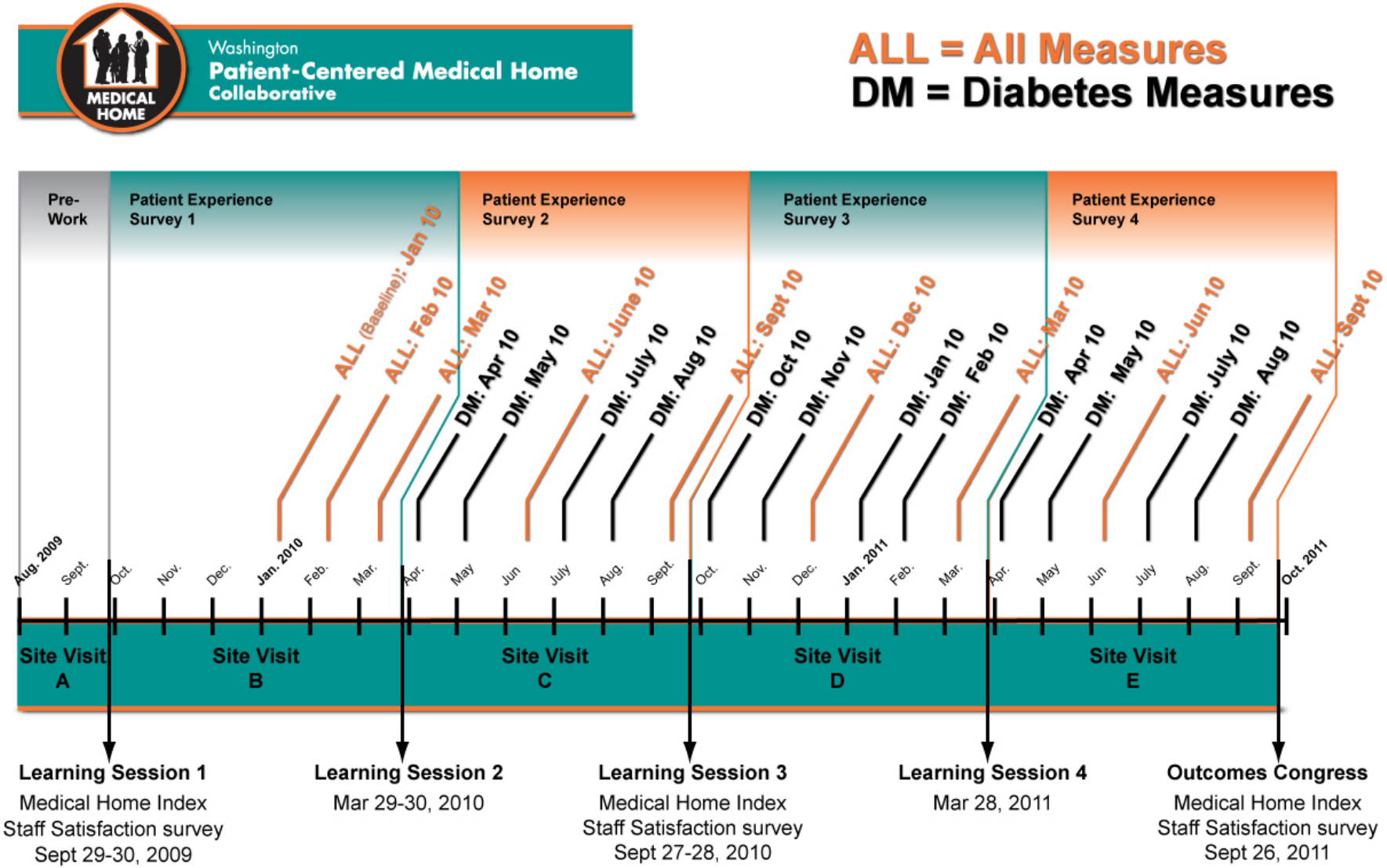

APPENDIX C

A Summary of the Evidence on Medical Homes

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Washington Patient-Centered Medical Home Collaborative
December 2009

Useful definitions:

Term	Definition	Source (below)
Care coordination	"Care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care." "Care coordination encompasses both health care and social support interventions across the range of settings from home to ambulatory care to the hospital and post-acute care."	11
Chronic condition	"Likely to last more than one year, limits a person's activities and may require ongoing medical care." "Care for people with chronic conditions consumes 78 percent of all health care spending, 95 percent of Medicare spending and 77 percent of Medicaid spending for beneficiaries living in the community."	13
Adaptive reserve	"Includes such capabilities as a strong relationship system within the practice, shared leadership, protected group reflection time, and attention to the local environment."	10

Summary of evidence arranged by research article

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
1. Grumbach, Bodenheimer, Grundy, The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009, pcpcc.net		
1. Gottilieb, Sylvester, Eby, Transforming your Practice: What Matters Most, Family Practice Management, January 2008		
2. Reid, Fishman, Yu, Ross, Tufano, Soman, Larson, Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental Before and After Evaluation, The American Journal of Managed Care, Vol. 15, No. 9 September 2009	Structural and team changes: • Smaller physician rosters • Physician medical assistant pairing. • Team member co-location. • Longer standard visits • Automated phone call routing system. • Dedicated desktop medicine time. Point of care changes: • Communication of team roles to patients. • Promotion of e-mail and phone visits. • Pre-visit chart review and visit planning.	Evidence reported: • Improved patient experience. • Decreased physician burnout. • Increased investment of $16 per patient per year recouped in 12 months by decrease in utilization, particularly in emergency services. • Improvement in “composite” measures of clinical quality. • Integration of email, telephone visits, and proactive care activities “integrated into workflow“by 12 months. Challenges noted:

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	• Real-time specialist consulting regarding electronic medical records (EMRs). • Collaborative care planning. • Motivational interviewing techniques. • EMR "best practice" alerts. • EMR health maintenance reminders. • Promotion of patient Web portal functions. • Redirect consulting nurse calls to team. Patient outreach changes: • New patient outreach. • Emergency visit and inpatient follow up. • Chronic disease medication outreach. • Outreach using care deficiency reports. • Group visit outreach. • Mailed birthday reminder care letters. • Abnormal test outreach • Promotion of electronic health risk assessment (e-HRA). • Promotion of self-management workshops. Management changes: • Daily team huddles. • Visual reporting system to track	• Largely capitated nature of enrollment and salaried physicians makes the applicability to fee-for-service settings unclear. (exemption from relative value unit based variable compensation model). • Multiple design components implemented at the same time makes it difficult to discern if particular elements were more or less responsible for the effects**.**

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	changes. • Rapid process improvement cycles. • Salary only physician compensation.	
3. Robert Graham Center, The Patient-Centered Medical Home: History, Core Seven Features, Evidence and Transformational Change, November 2007		
4. Paulus, Davis, Steele, Continuous Innovation in Health Care: Implications of the Geisinger Experience, Health Affairs Volume 27 Number 5, September/October 2008	Improvement strategies: • Highly collaborative change teams include clinical, operational, financial, payer, patient or consumer participants. • Design teams specifically target those provider services with the largest impact by patient population or resource consumption, those with evidence-based or consensus derived best practice and readily available metrics, those with the most interest from clinical champions or consumers or those with observed outcomes farthest from expected performance. Among these leaders select initiatives most likely to produce real impact quickly. • A clinical business case is developed. • Uses any number of improvement methods without exclusively focusing on a single approach.	Evidence reported: 1. "Early evidence" showed a 20% reduction in "all cause" admissions to hospitals. 2. Seven percent decrease in overall cost.

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	• "Organization's permission to try, fail, learn from failure and ultimately succeed." • Aligned incentives. Practice Innovations: • Personal health navigator; person who focuses on evidence-based care to prevent hospitalization, respond to consumer inquiries, promote health and optimize management of chronic illness. • Care "flows" for high prevalence chronic illnesses with a systematic, coordinated approach. • Home-based monitoring. • Interactive voice response surveillance. • Support for end of life care decisions. • 24/7 access to primary/specialty care. • Nurse coordinator in each practice site. • Predictive analytics to identify risk trends. • "Virtual" care management support. • Electronic health records access for all participants including physicians, care managers, and patients (Patient Portal). • Practice based payments. • Performance reports.	
7. O'Malley, Tynan, Cohen, Kemper, Davis, Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications, Center for		

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
Health System Change Research Brief, April 2009		
8. Coleman, Eilertson, Kramer, Magid, Beck, Connor, Reducing Emergency Visits in Older Adults with Chronic Illness: A randomized controlled trial of group visits, March-April 2001 Effective Clinical Practice, Volume 4 Number 2	Monthly group visits for chronically ill older adults in group model health maintenance organization in Denver, Colorado (Kaiser Permanente). • Monthly visits included a primary care physician, nurse and pharmacist. • Visits emphasized: o Self-management of chronic illness o Peer support o Regular contact with the primary care team.	• 295 older adults (>60 years of age) with frequent utilization of outpatient services and one or more chronic illnesses demonstrated reduced emergency department utilization.
9. Milstein, Gilbertson American Medical Home Runs, Health Affairs, Volume 28 Number 5, September-October 2009	"Common Pivotal" features: • Exceptional individualized care for chronic illness, tailored to prevent emergency department use and unplanned hospitalizations for chronic illness. This commitment implicitly embedded several or all of the following "exceptional caring promises." 1. We will take enough time during office visits to fully understand your illness and self-management capability and fine tune your treatment plan. 2. Between office visits we will directly	Practices selected as "home runs": • Average annual per capita combined payer and patient out-of-pocket spending for all covered health services was at least 15 percent lower after adjusting for health spending risk factors such as age and diagnosis. • Scores on publicly released or payer collected measures of quality and patient experience generally equaled or exceeded average regional scores. Unique characteristics of the four offices:

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	provide or mobilize the help you need to succeed in implementing your self-management plan with special emphasis on medication management. 3. We will serve your promptly 24/7 when you ask for urgent help between visits. 4. We will link you with a small group of carefully selected specialists with whom we actively coordinate. 5. We care personally about protecting you from health crises. • Efficient service provision: o Standardized care practices enables use of advanced registered nurse practitioner (ARNP) instead of MD, ARNP's with registered nurses (RNs). RNs with licensed practical nurses. o Greater use of health information technology. • Careful selection of and coordination with medical specialists. Concentration of referrals allows: o Greater standardization of treatment protocols. o More reliable transfers of	• Persistence. • Risk tolerance. • Instinct for leverage on clinical and financial outcomes. • Personal accountability-regarded emergency hospitalization and ED use as personal failure.

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	information. o Greater clarity regarding division of responsibilities. o Extend customer service model by reserving half day or full day of specialist's weekly schedules.	
10. Nutting, Miller, Crabtree, Jaen, Stewart, Stange, Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home, Annals of Family Medicine, Volume7 Number 3, May/June 2009	Qualitative lessons learned: • Change requires a whole practice re-imagination and redesign and is much more than a series of incremental changes. • The multiple components of patient centered medical home (PCMH) are highly interdependent. • Most current practice models are designed to enhance physician workflow. The PCMH should be designed to enhance the patient experience; this shift requires a transformation, not incremental change. • New technology implementation is more difficult and time consuming than originally envisioned. • To function in this team-based environment, physicians need facilitative leadership skills instead of the more common authoritarian ones. • Focus must expand from one patient at a time to proactive population-based approach, particularly for chronic care and prevention services. • Physician/patient relationships much shift toward a style of relationship-centered partnership to achieve patient goals rather than merely adhering to clinical guidelines. • Transformation requires a strategic developmental approach that starts with assuring a strong structural core and implements small changes to build adaptive reserve. • Transformation is a local process: tailor the approach to the practice. • Assure adequate financial resources; transforming to a PCMH costs dollars. • Assist physicians with their personal transformation: to learn the "new doctoring skills."	

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	• The National Committee for Quality Assurance should modify its accreditation process. • Establish realistic expectations for time and effort required. • Develop a practice technology plan; be flexible and reflective. • Monitor change fatigue. • Learn to be a "Learning Organization."	
11. Brown, The Promise of Care Coordination: Models That Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness, A Report Commissioned by the National Coalition on care Coordination. Mathematica Policy Research, March 2009 Key references: Chad Boult's 2008 survey of the literature Findings from the Medicare Coordinated Care Demonstration Project (Peikes et. al.)	Three types of interventions demonstrated to be effective in reducing hospitalizations for Medicare beneficiaries with multiple chronic conditions who are in general not cognitively impaired: • Transitional care interventions in which patients are first engaged in the hospital and then followed intensively over the four - six weeks after discharge by an advanced practice nurse. • Self-management interventions that engage patients for four - seven weeks in community-based programs designed to "activate" them in the management of their chronic conditions. Education provided by a mix of medical and trained non-medical professionals. • Coordinated care interventions that identify patients with chronic conditions at high risk of hospitalization, conduct initial assessments and care planning and providing ongoing monitoring of patient's symptoms and self-care	Evidence reported: • Reduce hospitalizations • Reduce overall cost of care and cover the cost of the intervention. Challenges noted: • If medical homes try to serve too broad based a population with all services, they are "unlikely to be successful." • "That is, the medical home model, even if implemented well, is unlikely to generate savings for low risk cases." (pg.22) • Large clinics, group practices and academic medical centers may have the array of staff and resources to build these teams; small physician practices of one or two physicians (83 percent of practices and 45 percent of all physicians) have to link to community health teams (reference to Community Care of

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	working with the patient, primary care physician and caregivers to improve the exchange of information. Six factors that distinguished the three of the 15 programs in the Medicare Coordinated Care Demonstration Project (MCCD) who were able to reduce hospitalization and costs over the first four years of operations: 1. Targeting - Target those at substantial risk of hospitalization in the coming year but not necessarily the most severe with high risk of repeated hospitalizations. **2.** In-person contact - Though all programs used some telephone contact, the successful programs averaged one in-person contact per month; far higher than most unsuccessful programs. 3. Access to timely information in hospital and emergency room admissions. Learning about acute episodes in a very short time is a critical factor. Patients are particularly vulnerable and there is a "heightened opportunity to explain how better adherence and self-care may prevent such occurrences." 4. Close interactions between care coordinators and primary care physicians.- Two primary factors affect the strength of the relationship:	North Carolina). • Large scale "disease management" telephonic programs have shown little or no success in credible randomized trials. • Even the most successful MCCD programs have generated reductions in Medicare costs of no more than $100 to $120 per member per month over their full population served and that is "barely enough to cover the program's fees, leaving no net savings. However, combining all three components* in a single program should yield greater cost reductions and could generate net savings." *****Transitional care interventions, self-management interventions, coordinated care interventions**.**

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	• The opportunity to interact face-to-face on occasion. • Same care coordinator working with all the program patients for given primary physician. 5. Services provided - All successful programs focus on: • Assessing. • Care planning. • Educating. • Monitoring. • Coaching self-management. • Medication management is a particularly important driver of success. • Some clients require social supports such as assistance with daily living activities, transportation or overcoming isolation. The successful programs had staff who could arrange these needed services. 6. Staffing - The MCCD program relies on registered nurses to deliver the "bulk of the intervention, with each patient assigned to a particular nurse coordinator to create rapport and preserve continuity with the patient and the primary care physician.	

Article reference	Key change strategies	Evidence reported/challenges noted/qualitative lessons learned
	For some patients, social workers provide valuable assistance with assessing eligibility and arranging services such as: • Home delivered meals. • Transportation. • Emergency response systems. • Advanced care planning. • Coordination with home health agencies.	
12. Rosenthal, The Medical Home: Growing Evidence to Support a New Approach to Primary Care, JABFM, September/October 2008, Volume21 Number 5		

Research questions/issues for ongoing investigation

Article reference	Questions/issues
11. Brown, The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness, A Report Commissioned by the National Coalition on Care Coordination. Mathematica Policy Research, March 2009	• How to identify the optimal target population for care coordination. • Recent unpublished work conducted by the author and colleagues suggests that the target population for care coordination should include those who have high-risk conditions (congestive heart failure, coronary artery disease or chronic obstructive pulmonary disease) and who have a hospitalization in the past year plus those with any chronic conditions that have multiple hospitalizations in the past two years. • Episodic versus continuous enrollment/eligibility for care coordination. • How best to provide transitional care interventions. • How to provide care coordination as efficiently as possible. • What mix of medical care interventions and social service supports is most effective?