The Medical Home Moment

Why It Makes Sense to Adopt the PCMH Model in 2013

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The goal of a patient-centered medical home (PCMH) is to deliver greater coordination of care through provider teamwork, patient communication, care management, and technology. Mounting evidence shows the PCMH model improves care outcomes and reduces costs. Yet most medical groups are reluctant to adopt this approach. The barrier is money. Although funding opportunities are expanding, most payers do not offer additional dollars for medical home care. A PCMH represents additional operating expenses with little or no increase in operating revenue.

The medical home model is a comprehensive response to healthcare reform.

Given financial realities, does it make sense to adopt the medical home model now? A growing number of medical group leaders think it is.

First, the immediate benefits are real. Pilot programs across the country show that medical homes improve access to care, help ensure patients receive optimal care, and reduce utilization of high-cost resources.

Second, the medical home model is a comprehensive response to healthcare reform. Many groups find that a PCMH consolidates compliance with several programs—including the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS) and electronic health record (EHR) incentive programs (Meaningful Use). A PCMH also supports participation in clinical integration initiatives and accountable care organizations (ACOs). In addition, the model can help groups prepare for future reform initiatives since it aligns with the “Triple Aim” of improving patient care, improving population health, and reducing healthcare costs.

Third, the medical home model provides a clear plan of action. Unlike many recent initiatives, the PCMH model developed by the National Committee for Quality Assurance (NCQA) provides a straightforward platform of standards, performance factors, and scoring. Well-defined medical home certification platforms have also been developed by the Utilization Review Accreditation Commission (URAC), Accreditation Association for Ambulatory Health Care (AAAHC), and the Joint Commission (JCAHO). Groups that are reluctant to pour resources into a vague strategy are embracing PCMH.

The NCQA medical home recognition program is for primary care physicians (a specialist program is in development). Successful early adopters have used a systematic approach to achieving NCQA recognition. The key is to develop a step-by-step plan for transforming the way your group delivers patient care.

A Quick Start Template

The 2011 NCQA medical home program is built around 27 performance elements. Each element is assigned a value ranging from 2 to 6 points. Six elements are “must-pass” standards. Remaining elements are
optional, but a practice must achieve a minimum of 35 points to qualify for Level 1 recognition, 60 points for Level 2, and 85 points for Level 3.

The good news is that most medical groups qualify for more points at the outset than they perceive. We recently worked with a Chicago-area community health clinic seeking to secure PCMH recognition. Clinic leaders initially self-assessed at 29 points, but a closer examination showed that the practice already qualified for approximately 60 points. The bad news is that for typical medical groups, these initial points do not include most of the must-pass elements.

The first step is to create a project leadership team consisting of administrative and medical staff leaders and personnel from key areas such as IT and practice operations. Since the medical home model will have a big impact on clinical processes, it is important to involve a physician champion who will engage the entire staff in the transition.

The next step is to perform a gap analysis. Go through the PCMH elements one by one and determine whether your group is currently fulfilling the requirements. Each element comprises a number of “factors”—scored items that define achievement of the element. For each element the group is not currently achieving, determine how important the element is and how difficult it would be to fulfill its factors. The “PCMH Gap Analysis” sidebar on page 36 illustrates how to identify your group’s performance gap for both individual elements and overall PCMH recognition.

**Medical home funding is small but increasing.**

To establish project goals, stratify the elements. Obviously, must-pass elements are core objectives. These include key medical home goals such as managing care (element PCMH 3C) and supporting self-care (PCMH 4A). Other elements that are both important and easily attained—the low-hanging fruit—should be classified as “priority one” objectives. Categorize difficult but important elements as “priority two” objectives. For most groups, achieving must-pass, priority one, and a handful of priority two goals will result in enough points for Level 3 recognition.

Finally, create a project plan. List tasks required to meet targeted objectives and assign responsibilities with milestones and deliverables. Create a documentation library within your computer system to collect the reports, policies, protocols, screenshots, training and education records, etc., required to verify your efforts. As mentioned above, medical home funding is small but increasing. Money has recently been available through the CMS Innovation Center, a handful of private payers, and some state-level family practitioner and pediatrics associations. As part of the planning process, group leaders should identify and apply for promising funding opportunities. These opportunities will not pay for your medical home, but they can subsidize transition and development costs.

**Overcoming Technology Barriers**

A key aspect of the PCMH model is using technological tools to improve communication and continuity of care. Unfortunately, technology is a barrier for many groups. To take full advantage of IT, medical groups must overcome resource limitations and change long-standing workflows.

Most groups’ biggest technology challenge is population management. PCMH 2D (a must-pass element) calls for medical homes to manage patient populations using patient data and evidence-based guidelines. However, most electronic medical record (EMR) systems lack strong care coordination functionality for managing patient care plans. The missing piece is structured data—dedicated data fields that can be searched and reported. For instance, when charting a diabetic patient using a rudimentary EMR, the physician records information about foot exams, eye exams, etc., in the notes field and attaches lab results as scanned documents. However, this unstructured data cannot be used to generate reports on the practice’s diabetic population. The practice ends up treating diabetics “one by one,” not as a total population that can benefit from coordinated care management.

To act as a medical home, a group must be able to report on data. Factor 2 of PCMH 2D, for instance, requires practices to provide patient populations with reminders about chronic care services. A medical group could fulfill this factor by using structured HbA1c data to generate a list of patients with uncontrolled diabetes and then provide appropriate reminders on annual eye exams or routine diabetic foot care.

Population management technology can be expensive. Upgrading a basic EMR with disease registries is one option, but medical groups can also use lower-cost workarounds to enable specific population queries. Either way, clinical staff must adopt new documentation practices to ensure clinical information is reportable.

The good news is that groups can save money by using IT to automate population management. Consider referrals for diabetic foot exams. Under the usual process, a staff member manually fills out a referral sheet and records it in a referral log. Another staffer might
check later to see whether the patient actually had the exam but will most likely omit any followup because of time constraints. Under an automated process, the EMR system uses a template to prepopulate the referral form, saving staff time. If proper networking is in place, the system itself can track whether the referral order was fulfilled. The system can then generate automated reminders in different formats, including secure messages delivered through a patient portal. As an added benefit, providing referral reminders through a patient portal will help you comply with Stage 2 Meaningful Use.

From Episodic Care to Value-Based Care

Transitioning to a medical home model can require significant cultural change. All clinicians must widen their focus from the individual encounter to the overall health of the patient population. PCMH 3 provides clear guidance on planning and managing patient care.

The first step is to identify evidence-based care guidelines for one or more medical conditions or problems (PCMH 3A) and identify high-risk patients and complex patients (PCMH 3B). PCMH 3C requires a medical home to apply care management practices to at least 75 percent of the patients in its target condition/high-risk/complex population. The performance factors of PCMH 3C represent a good start at a comprehensive care management effort (see “Developing a Care Management Process” sidebar). The thing to keep in mind is that practices do not need to meet all seven factors. Fulfilling just three factors will satisfy this must-pass element.

Strong care management requires an effective care team model. The goal is to transition from physician care supported by clinical staff to patient-centered care directed by a physician. PCMH 1G provides useful guidance. Important factors under this element include defining team member roles (factor 1) and holding regular team meetings and huddles (factor 2). Successful care teams use staff to the top of their licensure and delegate tasks downward whenever possible. Using standing orders (factor 3) is an effective way to utilize support staff while allowing physicians to focus on more complex patients. Another best practice is to cross-train nurses and assistants for defined roles within the care team.

For most successful medical home practices, a key change in care team design is the addition of nurse navigators. The medical home model adds significant additional work in the areas of care management and care coordination. A nurse navigator is essential for identifying chronic disease and wellness patients, managing their care plans, developing patient education programs, providing self-management support, tracking performance metrics, coordinating services, and initiating followup actions.

Addressing Physician Concerns

The transition to team care often raises concerns for physicians. Most worry that the medical home model will demand even more of their time. The key to addressing this concern is to actively develop a team model that effectively leverages physician expertise.

The team model delegates routine functions downward, freeing the physician for more challenging work. A physician might evaluate new patients and

PCMH Gap Analysis

Begin the medical home planning process by evaluating your current status within the NCQA scoring system. First, determine current and targeted performance for individual elements, as in this example:

<table>
<thead>
<tr>
<th>PCMH 4B: Provide Referrals to Community Resources</th>
<th>Points Available: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor (paraphrased)</td>
<td>Current</td>
</tr>
<tr>
<td>Maintains a current resource list</td>
<td>•</td>
</tr>
<tr>
<td>Tracks referrals provided to patients</td>
<td>•</td>
</tr>
<tr>
<td>Arranges or provides treatment for mental health/substance abuse</td>
<td>•</td>
</tr>
<tr>
<td>Offers opportunities for health education programs</td>
<td>•</td>
</tr>
</tbody>
</table>

In this example, a medical group initially fulfills only 1 factor of PCMH 4B. Adding referral tracking and education programs will enable the group to meet 3 out of 4 factors, qualifying it for 75 percent of available points (or 2.25 points total). The next step is to roll together point totals for all 27 elements. Overall, the group is 17 points away from Level 1 recognition (assuming it achieves all “must-pass” elements):

<table>
<thead>
<tr>
<th>PCMH 1: Enhance access &amp; continuity</th>
<th>Current Points</th>
<th>Target Points</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13</td>
<td>15</td>
<td>-2</td>
</tr>
<tr>
<td>PCMH 2: Identify &amp; manage patient populations</td>
<td>14</td>
<td>16</td>
<td>-2</td>
</tr>
<tr>
<td>PCMH 3: Plan &amp; manage care</td>
<td>8</td>
<td>12</td>
<td>-4</td>
</tr>
<tr>
<td>PCMH 4: Provide self-care support &amp; community resources</td>
<td>4</td>
<td>8</td>
<td>-4</td>
</tr>
<tr>
<td>PCMH 5: Track &amp; coordinate care</td>
<td>17</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>PCMH 6: Measure &amp; improve performance</td>
<td>12</td>
<td>17</td>
<td>-5</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>85</td>
<td>-17</td>
</tr>
</tbody>
</table>
then work with a nurse navigator to draft individualized care plans. The navigator will then introduce patients to the PCMH model of care, provide education, and coordinate services. Followup visits might be performed by a nurse practitioner, who may also own the task of updating the care plan and monitoring outcomes. A medical assistant (MA) could handle initial assessment and intake during future visits. The MA could also be responsible for outreach to patients for missed appointments or care plan gaps, based on protocols established under the direction of the physician. An RN could use protocols to review test results and prescription refills, forwarding only abnormal results and requests to the physician.

Another common physician concern is the selection of quality measures. PCMH 6A requires practices to track various performance measures, such as preventive care measures and chronic or acute care clinical measures. To select appropriate measures, generate a report from your group’s practice management system to identify top diagnoses. For a primary care practice, the report may show that diabetes, asthma, and women’s wellness are the top three conditions treated. The practice can then create quality measures around these patient conditions or visit types.

**Assigning Key Values**

In many cases, physicians agree on which conditions to measure, but disagree on assigning key values. For instance, the medical staff may be split on how to define uncontrolled diabetes. Do good doctors take action when HbA1c is above 9.0 or above 7.5? In situations like this, emphasize the importance of adhering to national standards. Nationally accepted quality measures can be obtained from CMS’s PQRS, NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS), MU Clinical Quality Measures (CQMs), ACO or clinical integration program metrics, or measures recommended by specialty associations. (See the “Comprehensive Diabetic Care: Measure Crosswalk” sidebar.) No matter what measures the medical staff selects, group leaders should maintain individual performance scorecards to help physicians monitor their outcomes.

Many physicians are concerned about the problem of noncompliant patients. Physicians know from experience that it is impossible to engage a certain number of patients on medical home activities and goals. To address this concern, help physicians focus on the fact that noncompliant patients will be outliers within the practice population. From a data analysis viewpoint, noncompliance fits in with the concept of population management. For example, consider a practice with 400 hypertensive patients, of which 16 absolutely refuse to cooperate with care. A noncompliance rate of 4 percent falls within expectations for a large patient group.

Another way to address this concern is to emphasize the goal of building patient support systems. An increasing number of practices are creating walking clubs and similar programs to help patients achieve important health goals. The PCMH model also makes room for physicians to provide personal support. We spoke recently with a physician who was puzzled by a diabetic patient’s consistently high blood glucose readings. The patient seemed to be doing everything right in terms of medications, exercise, and diet, so the doctor could not understand why his patient was not doing better. Working within the medical home framework, the physician took the time to talk with the patient about his daily routine. The breakthrough came when the patient said, “And right before bed, I..."
have my bottle of Gatorade.”

The patient had never understood that high-carbohydrate sports drinks are not allowed in the diabetic diet. In this instance, the medical home model freed the physician to focus on a complex case, provide personal attention, and achieve a positive resolution.

**Challenges and Opportunities**

There are several challenges to implementing the PCMH model. One is that many standards require coordination across several different functional areas. For example, PCMH 1A (access during office hours) impacts office workflows, clinical processes, and IT systems. Coordinating all these components is a practical and political hurdle.

Another challenge is that the medical home model will push many staff members to a new level of expectation. For instance, PCMH 6C requires medical home staff to develop new skills in quality performance improvement. Instilling new behaviors will require a cultural shift around a shared vision—the ability to quantify improved outcomes based on the care provided to your patient population. This underscores the importance of physician leadership in developing a medical home. Physicians must fully endorse the medical home model in order to spur the necessary cultural transformation.

While setting manageable goals is important, a minimalist approach to the PCMH model is ultimately counterproductive. Successful medical groups see PCMH recognition as a launchpad for strengthening engagement with patients, employers, and payers.

For example, PCMH 5C calls for practices to identify patients admitted to a hospital, obtain discharge summaries, and perform other activities to coordinate care around admissions. Medical groups should consider taking this element one step further by working proactively with hospitals to actually reduce readmissions. This is not a requirement under the NCQA program, but it is one way to create a platform for building future value within the PCMH model.

Pursuing opportunities like this will help medical groups realize a positive return on a medical home investment. And groups that get started now will be more attractive partners for hospital-led clinical integration initiatives in the years ahead. Ultimately, these groups will be able to turn the medical home model into a long-term strategy that pays off in stronger payer relationships and better patient outcomes.

**References**


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