Physician-Driven
Patient-Focused
Practice-Centric
Medical Home: A Pragmatic
Approach to Recognition

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Executive Summary

The Patient Protection and Affordable Care Act of 2010 (PPACA) is here to stay, and it includes a host of initiatives small and large, targeting massive transformation of the health care delivery system. One of those initiatives involves the adoption of the principles of a Patient Centered Medical Home (PCMH) for primary care as formulated by the primary care medical associations, and to a large extent, as translated into operational processes by the National Committee for Quality Assurance (NCQA). There are other implementations of the medical home put forward by public and private organizations, but NCQA’s Medical Home recognition program is considered the gold standard for PCMH.

Although early results of PCMH initiative are encouraging, primary care practices attempting a transition to a medical home model of care and formal NCQA recognition, are often encountering significant barriers. Primary care that is continuous, comprehensive and coordinated requires an infrastructure and activities that are seldom reimbursed by payers, and the PCMH recognition process, when viewed separately, imposes additional administrative work on already overwhelmed primary care physicians.

Existing PCMH support frameworks are unnecessarily complex, fraught with misconceptions, resource intensive, focused on benefits to stakeholders external to the primary care practice, and are not cost-effective.

This whitepaper will attempt to draw a new and different roadmap towards the primary care medical home as envisioned by the primary care physician associations, and as operationalized by the NCQA recognition program; a pragmatic roadmap that is driven by practicing physicians and is customized to the unique needs of each practice; an approach to excellence that is simple, comprehensive, scalable, affordable and designed to serve those who care for patients day in and day out.

If you randomly ask a primary care physician about his/her opinion on the Patient Centered Medical Home (PCMH) model of primary care, you will most likely get one of the answers listed below in order of increasing prevalence:

1. Absolutely fantastic way to practice medicine. We’ve been doing this for a while and are a Level III recognized Medical Home.
2. The idea is good and we are currently making the transition and working on obtaining NCQA recognition. It’s not easy, but we are hopeful.
3. We are part of a PCMH pilot in our state. It’s a lot of work and I am not convinced that it will have any benefits for my practice.
4. I read about it, but I can’t afford to hire dieticians and social workers and spend time on all the paper work.
5. I don’t have time for this. Just a bunch of government regulations that do nothing for patient care.
6. This is the final nail in the coffin of primary care. It’s going to drive all remaining independent physicians out of practice, which is what the government wants anyway.
7. My mother-in-law is in an assisted living facility, but other than that I don’t have any patients in nursing homes….. I don’t take Medicaid.
8. Say that again….?
The Primary Care Medical Home

The medical home concept was introduced by the American Academy of Pediatrics\(^1\) in 1967 in reference to supervision of health care for chronically ill children, and the need for complete medical records to facilitate such supervision by the primary care physician. The primary care medical home was proposed to be the place where medical records were aggregated and acted upon to enable optimal care for the child.

Forty years later the primary care associations jointly formulated broader principles for a patient centered medical home model of care\(^2\) to describe care that is continuous, comprehensive, coordinated, evidence-based, highly accessible and provided by a personal physician and his or her team, supported by adequate payment for enhanced services and assistive technologies, such as electronic medical records, patient and disease registries and health information exchange across care facilities.

The Patient Protection and Affordable Care Act of 2010\(^3\) recognized the foundational role of primary care\(^4\) and the medical home in achieving the triple aim of health care reform, better care for individuals, better population health, at lower costs, and is therefore encouraging the broad adoption of the medical home model of care through a variety of initiatives funded by both public and private insurers. For instance, primary care and the medical home model are at the heart of Accountable Care Organizations (ACO).

In recent years medical homes have been shown in some studies to reduce costs of care, improve quality measures, reduce disparities and have a positive effect on both physicians and patients’ satisfaction. A recent report from the Patient Centered Primary Care Collaborative\(^5\) (PCPCC) surveyed evaluations of multiple medical home projects across the U.S. reporting significant reductions in ED utilization and hospital admissions and readmissions, while utilization of primary care increased, and a variety of preventive and chronic care measures improved.

### Sample Patient-Centered Medical Home Initiatives

<table>
<thead>
<tr>
<th>Organization</th>
<th>ED Utilization</th>
<th>Inpatient Utilization</th>
<th>Primary Care</th>
<th>Quality Metrics</th>
<th>Overall Costs</th>
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<td>Geisinger Health System Proven-Health Navigator</td>
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*Abstracted from: Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012, Patient Centered Primary Care Collaborative*
The NCQA 2011 PCMH Recognition Program

In 2008 the National Committee for Quality Assurance (NCQA) created a formal process by which primary care practices that incorporated the first six joint principles in their practice could be recognized as Patient Centered Medical Homes, providing recognized practices with a vehicle for obtaining the appropriate payment listed in the seventh principle.

The NCQA recognition program operationalizes the Joint Principles of the Patient Centered Medical Home through the definition of six standards (PCMH 2011):

PMCH 1: Enhance Access and Continuity
   Same day appointments, after hours access, team work....
PMCH 2: Identify and Manage Patient Populations
   Collect and use clinical data for population management..
PMCH 3: Plan and Manage Care
   Evidence based, identify high risk patients, manage care...
PMCH 4: Provide Self-Care Support and Community Resources
   Engage patients, care plans, use community resources......
PMCH 5: Track and Coordinate Care
   Orders, referrals, transitions of care track and follow-up...
PMCH 6: Measure and Improve Performance
   Implement, measure, report on Quality Improvements

These standards, or concepts, consist of 28 Elements and 152 individual Factors, or measures that a primary care practice should satisfy in order to be recognized as a 2011 PCMH by NCQA.

NCQA allows three levels of recognition, based on the number of points a practice accumulates for the various Factors and Elements, six of which are required for recognition at any level (see box).

<table>
<thead>
<tr>
<th>Recognition Level</th>
<th>Points</th>
<th>Must-Pass Elements</th>
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</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>85 – 100</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 2</td>
<td>60 – 84</td>
<td>6 of 6</td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
<td><strong>35 – 59</strong></td>
<td><strong>6 of 6</strong></td>
</tr>
<tr>
<td>Not recognized</td>
<td>0 – 34</td>
<td>&lt;6</td>
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The transition to a medical home model of care is not trivial and the administrative complexity is quite significant. It may take an average practice anywhere between one to two years to accomplish the highest level of recognition with or without assistance from consulting entities.

As of March 2013 there were 5,429 primary care practices in the U.S. recognized by NCQA as Patient Centered Medical Homes.

(Source: ncqa.org)
An Informal Review of the NCQA Standards

When exploring the medical home model of primary care, it is important to keep in mind that the PCMH concept is based on a statement made by physician associations attempting to define good primary care and the need for insurers to pay more for such excellence. There are many misconceptions regarding the transition to a medical home practice model in general and the NCQA PCMH recognition program in particular. Over the following pages, the requirements for the gold standard approach to PCMH recognition, as offered by NCQA, will be examined from an informal physician/practice perspective, stepping through the six NCQA recognition Standards in order.

Your Practice - Your Way: Tip #1
Start small and thread carefully:
1. Reserve just a few “open slots” every day
2. Begin tracking patient calls

Availability after hours and seeing patients the same day as much as possible. It is not an easy task to start tinkering with your schedule, if you are not currently offering same-day appointments, and done haphazardly, it may have serious financial implications to your practice. However, when correctly implemented, enhanced access has been consistently linked to better quality, lower costs and in some instances, lower operating costs. That said, for a solo or very small practice, extended access could be problematic, and may require some creative thinking. How would your patients react if, say, every Tuesday you’d start seeing patients from 12 pm to 8 pm? Or if you closed early on Wednesdays and twice a month you saw patients on Saturday mornings? Or if you had an arrangement with a couple of other practices to provide urgent care at odd hours on a rotating basis?

PCMH1 - Enhance Access and Continuity – Continuity here refers to people having a personal physician instead of seeing whoever happens to have time that day. There are few practices where this is not the case anyway, but it’s hard to argue against the need to build a long term relationship between patients and their doctors, and it’s even harder to argue against this being the #1 foundational requirement of delivering high quality longitudinal patient care, particularly for patients with chronic conditions. Note that by definition solo practices are automatically set up to care for patients this way. The second part of this Standard is a bit more problematic from a physician’s point of view, because it does require availability after hours and seeing patients the same day as much as possible. It is not an easy task to start tinkering with your schedule, if you are not currently offering same-day appointments, and done haphazardly, it may have serious financial implications to your practice. However, when correctly implemented, enhanced access has been consistently linked to better quality, lower costs and in some instances, lower operating costs. That said, for a solo or very small practice, extended access could be problematic, and may require some creative thinking. How would your patients react if, say, every Tuesday you’d start seeing patients from 12 pm to 8 pm? Or if you closed early on Wednesdays and twice a month you saw patients on Saturday mornings? Or if you had an arrangement with a couple of other practices to provide urgent care at odd hours on a rotating basis?

The anatomy of a typical patient call

- Patient/parent initiates clinical call
- Triage
  - Go to ER
  - Go elsewhere
- Doctor/nurse will call back
- Patient “worked in” today/tomorrow
- Appointment made X weeks out
- Resolved?
  - Yes
  - No
  - Long wait?
  - Yes
  - No
  - Adequate?
  - Yes
  - No
  - Reminder
  - No-show
  - Loss

Cost

Done

Loss

Done

Go to ER

Cost

Done

Loss

Done

Go to ER

Cost

Done

Loss
PCMH2 - Identify and Manage Patient Populations – This one sounds onerous and a departure from individualized patient care, but is it really so? The “populations” term notwithstanding, all this Standard requires is that you document patient demographics and clinical information in the chart (seriously), that you take good histories and that you send reminders to your patients to monitor their chronic and/or preventive care needs. There is really nothing here that a good primary care physician doesn’t already do, and probably to a much greater extent than the NCQA standards specify. The one thing that may be different is that this Standard talks about proactive reminders to patients that don’t come in to see you on their own. Proactive care simply means that you, know who your patients are, know what their medical needs are, identify unmet medical needs and initiate offers for care to meet those needs. Good for business and definitely good for patient care on an individual level.

PCMH3 - Plan and Manage Care – Another statement of the obvious, but this standard uses some terminology that may raise some eyebrows. For example, it asks that your care is evidence-based. Is your care not evidence-based? Unless you throw darts at lists of diagnoses and therapies hanging in your office, you are “integrating individual clinical expertise with the best available external clinical evidence from systematic research” when you care for your patients. The goal here is to identify and implement strategies that make it easier for you to consistently deliver the best possible patient care.

And this is really all there is to this Standard, other than practicing medicine, i.e. seeing patients, evaluating conditions, planning care, talking to patients, and generally speaking, being their doctor.
PCMH4 - Provide Self-Care Support and Community Resources – This may sound like the new age fluff of patients taking care of themselves, and granted, there is some of that here, but the details are again pretty straightforward in their intent to have patients understand their conditions and do something about it. Primary care docs don’t usually fit the much publicized portrait of aloof and paternalistic doctors who won’t give you the time of day. It is the time constraints in fully loaded practices that may prevent some from fully engaging with their patients, and no certification process will change that without proper shift in reimbursement, or a change to a more direct practice model with smaller patient panels. This Standard’s feasibility is also highly dependent on patients themselves, but there are simple things you and your staff can do to better enable patients to take responsibility for their own health, some of which you are probably already doing, and most of which can be delegated to team members who are not billing providers.

PCMH5 - Track and Coordinate Care – Do you send patients to specialists and then forget all about them? Do you order lab tests and don’t care if the results come in or not, or if they are normal or not? Do you get calls from the hospital notifying you that one of your patients was admitted, and you hang up thinking that this is not your problem? No? Then you are tracking and coordinating care. Can you do more? Probably, but here you are largely at the mercy of specialists and hospitals in particular. You most likely already have tickler lists to help remind your staff about getting specialists notes and test results, but it is extremely difficult to have the hospital contact you if you are not admitting your own patients (and sometimes even if you are). There is effort (and costs) involved in better tracking and better coordination and payers are starting to take notice as evidenced by the latest care coordination CPTs added to the Medicare physician fee schedule.

PCMH6 - Measure and Improve Performance – Here it is. This is the measuring, reporting and all administrating bag of requirements, complete with patient satisfaction surveys, sending data to payers and using electronic medical records. While most items here are optional, a medical home is required to set some improvement goals for clinical measures (just goal setting, not necessarily outcomes). So after doing everything outlined in previous Standards, this is where the assumption is implicitly made that a medical home should be able to continuously improve the care it provides. Perhaps you believe that you are already providing excellent care, and no doubt most of you do, but is there anything more you can do? This Standard is asking you to consider this question, and if you have an answer, begin acting on it. And yes, this too may take more time and more effort on your part, and thus be dependent on payments to support these efforts.
A Pragmatic Roadmap to PCMH Recognition

The Things You MUST Do
Consider the 6 MUST PASS Elements and, for each, figure out the following
1. Are you currently doing enough to score at least 50%, and preferably 75%, on each Element?
2. Can you generate the required supporting documentation to substantiate your answers?
3. If you answered Yes to both questions, continue to the next step.
4. If you answered No to either 1 or 2, estimate the feasibility for you to remedy the situation.
5. If you decide to make changes to satisfy the MUST PASS Elements, go to the next step.
6. You should have approximately 25 points by now

The Things You Already Do
Go through the remaining Elements and find things you already do AND can easily generate documentation for
1. If you have attested to Meaningful Use, search for the Meaningful Use Elements and Factors
2. If you are still on paper, eliminate the Meaningful Use and electronic Elements right off the bat
3. It’s OK to pick only a few Factors from an Element
4. If you manage to accumulate 20 points or more during this step, you should be able to qualify for at least Level I recognition
5. If you have significantly less than 45 points so far, or if you desire Level II or Level III recognition, move on to the next step.

The Things You Want to Do
1. Go through the remaining Elements and identify the ones most capable of improving patient care
2. Make sure that the items you select are feasible to do AND to document properly
3. Keep your patients in mind when you select and make sure the factors are applicable to them
4. Try to not overburden one particular person on your team
5. By now you should definitely have enough points to comfortably qualify for a Level I, most likely a Level II, and possibly a Level III. If not, or if you want to achieve higher levels, go on to the next step.

The Things You Need to Do
1. Examine the remaining Elements and figure out a way to satisfy AND document more Factors
2. In the rare case where at this point you accumulated less than 45 points, you will need to consider engaging in additional activities that require significant effort and may not be worthwhile in your opinion.
3. Make a decision if you truly want to obtain PCMH recognition and know that the process will be very difficult for your practice
4. Consider putting in place some prerequisite capabilities first, such as an EHR, improved billing operations, or new payer contracting, before undertaking PCMH recognition.

Your Practice - Your Way: Tip #7
Keep the reviewer happy:
Make sure your documentation is well organized, readable, properly annotated, self explanatory and meets NCQA guidelines (approximately 3 documents per Element).

Your Practice - Your Way: Tip #8
Documentation is critical:
Example: PCMH 2A - You obviously are recording patient demographics, but can you generate a report showing that you are doing so for more than 50% of patients?

Your Practice - Your Way: Tip #9
Give yourself room for error:
Always submit materials for at least 10 points more than the Level you hope to be recognized for. Reviewers are human and their assessments may be different than yours.

Your Practice - Your Way: Tip #10
Don’t bite more than you can chew:
It’s OK to first apply for Level I or II recognition, catch your breath, and then apply for a higher Level.
You have 3 years to “Add On” to your initial NCQA recognition Level.
Build a Roadmap for Your Practice - Your Way

Research Your Options

1. Study the NCQA PCMH Standards and Guidelines available for free from NCQA\(^6\)
2. Call provider relations at your largest payers and find out if there are any financial incentives available in your State for PCMH recognition
3. Gather resources to assist with evaluation and management of PCMH recognition\(^20\)
   * Contact your EHR vendor and find out if they have a PCMH support program, or how they can help you (and how much is this going to cost you).
   * Identify free PCMH tools, resources and educational opportunities
   * Ask around, or check the NCQA listings, and try to find a similarly situated practice in your area that achieved, or is working on achieving, PCMH recognition. Talk to them.
4. Objectively assess your practice and the effort required from your practice to achieve recognition.
   * **DO NOT** mindlessly go through all 152 NCQA Factors answering Yes/No to all questions
   * **DO NOT** spend any money until you decide that this is something you want to do, you can do, or you absolutely have to do.
   * **DO** decide on your personalized roadmap to PCMH recognition
5. Understand that everybody in the practice will have to pitch in, but someone must be empowered and responsible for the overall project.
6. Understand that without physician involvement and unwavering support, the project will fail.

Make a Plan

A good project plan has the following components:

1. Timeline – decide when you are going to start work and estimate how much time each task requires
2. Prioritization – decide the order in which you will complete each task, and stick to your roadmap
3. Resource allocation – decide who is responsible for each task and set aside enough time for them to be able to work on the project
4. Milestones – select several important points on this journey and highlight them (e.g. complete MUST PASS Elements, enough points for Levels I through III, etc.)
5. Budget – decide how much time and resources you want to invest in this project. Consider:
   * fees for NCQA to review your application
   * time away from other work in the practice
   * fees for tools from your EHR vendor (if any)
   * consulting fees if you decide to use outside help
   * increased operational revenues and any PCMH incentives that are available to you
6. Kickoff meeting and regular project meetings (weekly or biweekly at a minimum) involving all resources and stakeholders (consider asking a patient or two to join you sometimes)

Focus on Your Patients

Whatever you do, don’t lose sight of the ultimate goal of improving patient care. It’s been said that true quality of care and practice transformation, whatever that may be, is largely independent of counting points, certifications, recognitions and formal testing, but **PCMH recognition is not a test**. The NCQA PCMH program is a flexible curriculum, and customizing a curriculum to incorporate the clinical expertise of physicians and the knowledge of practice teams, while providing hands-on opportunities to effect gradual change, is a time honored, and extensively proven, method for learning and quality improvement.

**This is your practice and these are your patients. You should be the one building your medical home.**
References


4. Starfield B, Primary Care: Balancing Health Needs, Services, and Technology, Oxford University Press, USA; Revised edition (October 29, 1998)


About BizMed

At BizMed we offer free web-based tools to simplify and accelerate your PCMH recognition, lighten your administrative burden, automate your paperwork and simplify the business of medicine for your practice. To learn how our software and services can help your organization contact us at bizmedsolutions.com