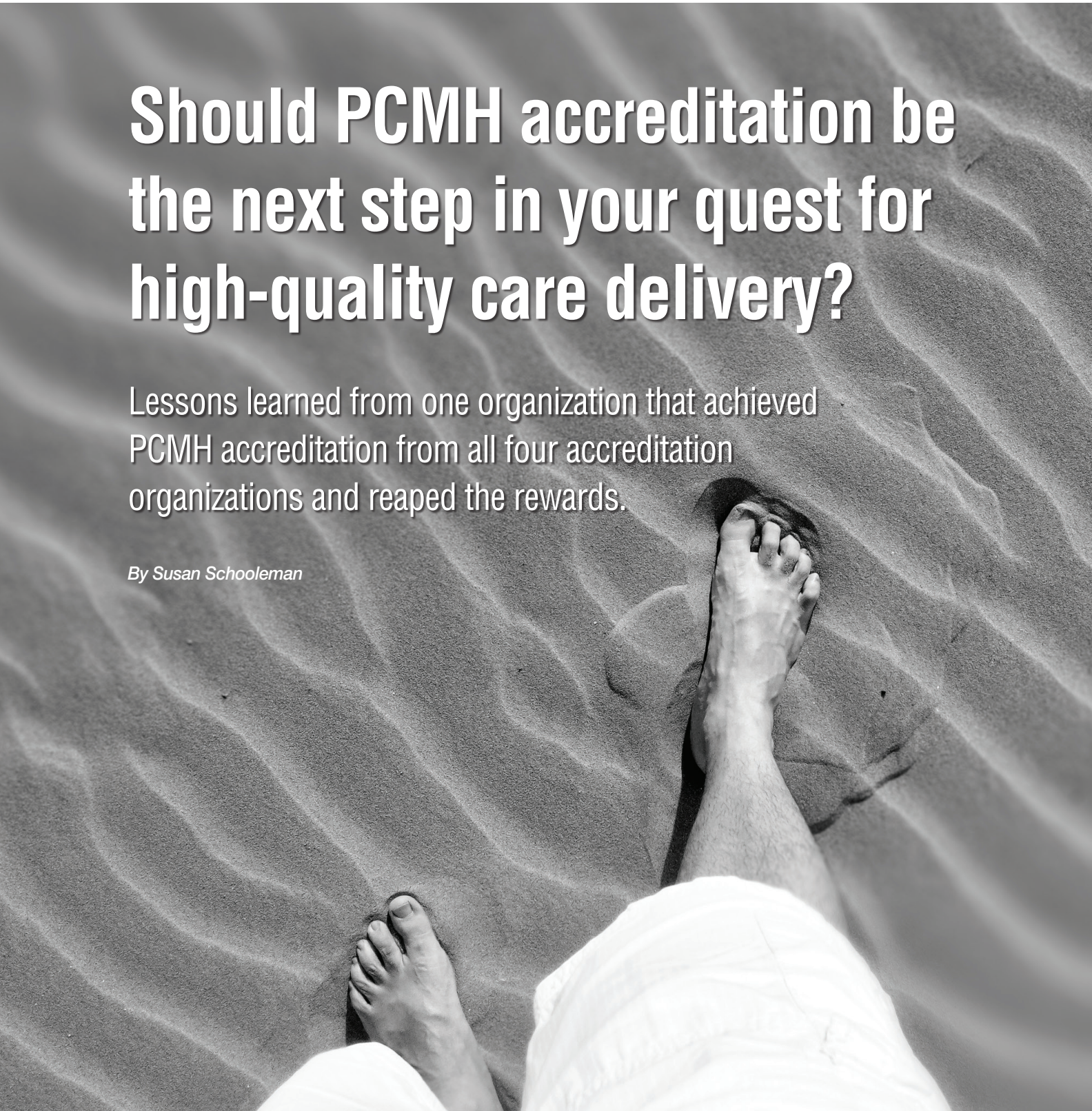
Should PCMH accreditation be the next step in your quest for high-quality care delivery?

Lessons learned from one organization that achieved PCMH accreditation from all four accreditation organizations and reaped the rewards.

By Susan Schooleman



The results of becoming one of the nation's first patient-centered medical homes (PCMHs) included the development of an electronic patient management system with chronic disease management and clinic decision support tools, population management with data analytics, active patient monitoring, higher rates of patient engagement and improved practice earnings for Southeast Texas Medical Associates (SETMA), Beaumont, Texas. Fourteen years ago the organization began defining and deploying principles and capabilities that would in 2010 lead SETMA to be recognized as a PCMH.

Today, SETMA, which employs 40 providers in six clinics, has achieved PCMH accreditation from all four accrediting bodies. About 38% of SETMA's total patient population has income below the poverty level. Of those, 95% have multiple chronic conditions that need to be managed and monitored. Patients with multiple chronic conditions are the ideal beneficiaries of PCMHs, according to a comparison of the four accreditation programs. (See sidebar, page 22.)

James L. Holly, MD, chief executive officer, SETMA, credits the PCMH approach for increasing SETMA's quality of care as documented through better patient outcomes and generating enough revenue to fund its not-for-profit foundation, which provides care for patients who cannot afford it."

We spend almost $192,000 a month on unreimbursed services to our patients, and annually SETMA's 12 partners give a half million dollars to the foundation," says Holly, who is also an adjunct professor of family and community Medicine at the University of Texas Health Science Center, San Antonio. "The very fact that we're able to do that — that's $2.5 million a year — shows that obviously, the return on investment from operating as a PCMH is good."

The goal to become a PCMH started evolving when SETMA's three founding partners (including Holly) attended the MGMA 1997 Annual Conference and sat in on a session about EHRs. After selecting and deploying an EHR the team determined about a year later that it was too expensive and hard to use if all they could do was document a patient encounter electronically.

"Immediately, we changed our goal from EHR usage to electronic patient management. We began building disease management tools, clinical decision support tools, and creating the ability to make the healthcare process easier," Holly says.

Passing the baton

Because the EHR allowed SETMA to manage the health conditions of its patients — following and actively engaging them — SETMA developed a new care delivery model with the following five steps:

- Tracking more than 300 quality metrics on each patient
- Auditing panels and populations of patients for provider compliance
- Analyzing patient outcomes to find points of leverage for performance improvement
- Public reporting by provider name and performance
- Developing quality improvement initiatives

The link between the patient encounter and the patient's year-long care is what Holly calls "passing the baton." Before it was instituted, a patient presented with a chief complaint a few times a year, and the provider reacted to it. With SETMA's new approach, providers

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pass the baton to the patients, asking them to improve their health by making better choices year-round.

Holly explains the importance of passing the baton to the patient this way: Every year has 8,760 hours, and in extreme cases, a patient who requires a lot of care might spend about 20 hours in a provider's office. This means that the patient is responsible for his or her care 8,740 hours a year. Without the activation and engagement of the patient, who takes the baton (an action that is formalized with shared decision-making), a patient's plan of care and treatment plan will fail, Holly says.

"This makes it clear that the patient is responsible for the overwhelming amount of his or her own care, which includes adherence with formal healthcare initiatives and with lifestyle choices that support health," he says.

To support patients, SETMA monitors them and reaches out by phone or email to check in.

For example, using data from the EHR, SETMA professionals noticed that, on average, patients' hemoglobin A1c (HgbA1c) rates were steadily improving. But the data revealed one subset of patients whose numbers were not improving. "By analyzing the standard deviation of the HgbA1c, we were able to reach out to patients whose values fell far from the average of the rest of the clinic," Holly says. The outreach worked, and providers were able to take the steps needed to ensure the subset's results coincided more closely with SETMA's general patient population.

SETMA uses the same EHR in all of its clinics as well as its affiliated hospitals, nursing homes and hospices. "Everywhere we see patients, we're tracking them in the same database. So the continuity of care based on data is perfect," Holly adds.

This process allows SETMA to improve its care delivery. For example, "We've discharged 21,000 patients from the hospital over the last five years, and 98.7% of the time, their hospital care summaries and post-hospital plans of care and treatment plans have been completed at the time they leave the hospital," Holly says. "That's a record no one can match. And that has made a huge difference, not only in quality of care but also in preventable readmissions and the things we continue to be able to do." This type of process re-engineering was made possible because of SETMA's commitment to the PCMH, he adds.

No payer reimbursement for PCMH

SETMA does not receive higher reimbursement because PCMH accreditations, but it does receive

a very small amount of compensation through the National Committee for Quality Assurance (NCQA) Bridges to Excellence program,[1] which rewards providers for quality care. "We get paid for diabetes and heart/stroke treatment due to the quality of our treatment," Holly says. "These payments represent 0.00053571 of our total collections, or 0.05371%," he adds. [Read more about payer-specific value-based programs: mgma.org/payerspecialissue.]

Functioning as a PCMH has also reduced costs and increased quality for Medicare Advantage patients, who generally are poor, have multiple health conditions and require more resources to manage, Holly says. About 40% of SETMA's patients are covered by Medicare Advantage (MA). SETMA has known since 1996 that its treatment of MA recipients is less costly compared with other provider groups. In 2011, Centers for Medicare & Medicaid (CMS) hired a nonprofit research organization to compare SETMA and other medical home practices with noncoordinated practices. SETMA treatment of fee-for-service Medicare patients was 37.4% less costly than the Medicare fee-for-service practice that it was benchmarked against.

PCMH accreditation services

SETMA received accreditation from all four PCMH accreditation organizations:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission
- NCQA
- URAC (formerly the Utilization Review Accreditation Commission)

Holly recommends the following steps for any practice that plans to become a PCMH:

- Pursue and achieve NCQA Tier 3 recognition for PCMH and deploy the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH program. "Our caution would be for an organization not to assume that this achievement is the end of the medical home pilgrimage, but that it is a good beginning," Holly says.
- Choose another accreditation body to evaluate the practice. "This provides assurances that the practice's safety and quality measures required to achieve continuous quality improvement are in place," he says.
- Seek a "practice culture assessment" for "maximum transformative purposes in patient-centered care" from Planetree, an international organization in Derby, Conn.

"In our judgment, any accreditation process should be educational as well as 'evaluational,'" Holly says. "So it is with [these] accreditations; you will learn more and more about yourself from each of these. The process within itself contributes to practice transformation."

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Note:

1. ncqa.org/Programs/Recognition/BridgestoExcellence.aspx

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A comparison of PCMH accreditation programs

Practices that become accredited as a patient-centered medical home (PCMH) should expect to receive increased reimbursement in the future for the care coordination and care management of their most chronic and costly patients, says David N. Gans, MSHA, FACMPE, senior fellow, MGMA Professional Development & External Relations, who recently compared the four PCMH accreditation organizations in *A Comparison of the National Patient-Centered Medical Home Accreditation and Recognition Programs* (mgma.org/store/ItemE8789). Some payers, including Michigan Blue Cross and Blue Shield, have increased reimbursement to PCMH-accredited practices to reward care management, Gans says. He believes this practice will spread.

As an example, Gans points out that last December's 2014 Medicare Physician Fee Schedule Final Rule[1] (mgma.org/feeschedule) describes that in 2015 the Centers for Medicare & Medicaid (CMS) plans to establish a separate payment for qualified practices that provide chronic care management services to patients with multiple chronic conditions.

In the PCMH report, Gans compares the following industrywide-accepted PCMH accreditation organizations:

- Accreditation Association for Ambulatory Health Care (AAAHC): 2013 Medical Home Accreditation Standards and 2013 Medical Home Certification Standards
- The Joint Commission: Primary Care Medical Home 2013 and 2014 Standards and Elements of Performance
- National Committee for Quality Assurance (NCQA): Standards for Patient-Centered Medical Home (PCMH) 2011 and 2014 Standards
- URAC (formerly the Utilization Review Accreditation Commission): 2013 Patient-Centered Medical Home Practice (PCMH) Certification Standard V1.1

Operating as a PCMH will have the most benefit for practices that treat patients with multiple conditions that need to be monitored, Gans says.

"If your practice has a majority of patients who are healthy, a PCMH will create a better patient experience and improve access, but will probably have no effect on your total patient healthcare costs. In fact, it might even raise the cost of healthcare because your patients are receiving more services from you," he says. "It's those patients who have multiple chronic diseases — your highest acuity patients — they're the ones who might offer cost savings because a PCMH keeps them out of the emergency department and out of the hospital." [Read more about population health approaches: mgma.org/pcmh.]

Although comparable, the PCMH accreditation processes vary, Gans adds. "The NCQA conducts a self-attestation with documentation. In other words, you submit a number of documents and attest that you do this." In contrast, URAC, AAAHC and Joint Commission use an on-site surveyor to assess the practice and make sure that it complies with their standards.

Gans suggests seeking PCMH accreditation by any of the organizations that have already accredited practices in another area. For example, if an ambulatory surgery center already received AAAHC accreditation, it should consider using AAAHC for PCMH accreditation. "Look at each of the programs [and] identify which one's going to best meet your needs," Gans advises.

Download the report:mgma.org/store/itemE8789.

Note:

1. NPRM Final Rule, U.S. Dept. of Labor, *Federal Register* 2013. Dec. 10;78(237): 589-607.