

White Paper

The Patient-Centered Medical Home and Your P4P Goals:
Your Guide for Getting Engaged and Generating Results Now

By Frank Irving

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The Agency for Healthcare Research and Quality, part of the U.S. Department of Health & Human Services, defines the Patient-Centered Medical Home (PCMH) as a model of primary care delivery that is patient-centered, comprehensive, coordinated, accessible and continuously improved through a systems-based approach to quality and safety.¹

Although adoption of the PCMH model is not mandated by any federal or state law, it is referenced in five areas of the Patient Protection and Affordable Care Act of 2010 (PPACA):²

1. The Center for Medicare and Medicaid Innovation will test and evaluate models that include medical homes as a way of addressing defined populations with either poor clinical outcomes or avoidable expenditures.
2. Medical homes are one indicator for measuring health plan performance; state health exchanges are designing incentives to encourage high-performance plans, including those with medical homes.
3. Starting this year, the federal government will match state funds up to 90 percent for two years to states that provide options for Medicaid enrollees with chronic conditions to receive care under a medical home model.
4. PPACA will provide grants to community care teams that organize themselves under the medical home model.
5. PPACA created the Primary Care Extension Program, which provides primary care training and implementation of medical home quality-improvement initiatives and processes.

The National Committee for Quality Assurance (NCQA), a private non-profit organization dedicated to improving healthcare quality, has taken a leadership role among medical home initiatives with its Physician Practice Connections (PPC) recognition program for PCMHs. PPC recognizes practices that use systematic processes and information technology (IT) to enhance the quality of care.³ According to NCQA, as of the end of 2010, almost 7,700 clinicians at more than 1,500 sites across the United States had received the organization's PPC-PCMH recognition.

On Jan. 31, 2011, NCQA released new standards for its PCMH program, with an emphasis on medical practices being more patient-centered and reinforcing "meaningful use" incentives⁴ (introduced in the HITECH portion of the American Recovery and Reinvestment Act of 2009), which provide Medicare/Medicaid reimbursement for practices

and hospitals that utilize specified functions of certified electronic health records (EHRs).

Against this backdrop, physician practices should assess or revisit their readiness – from both a technological and organizational standpoint – to pursue participation in the PCMH model.

Must-have components

Mark Blatt, MD, director of global healthcare strategy at Intel Corporation, brings 20 years of primary care practice experience to his overview of the PCMH model, with a particular interest in care coordination and delivery. He explains, "The technology that supports the medical home starts with the EHR, which includes a registry function to search for a series of demographics so you can identify cohorts. You need communication systems to inform patients, remind them, teach them and encourage them. You also need a communication system within the practice so that the care team can meet regularly to share data. And you need tools to provide care coordination seamlessly to peer workers within your team, workers in the extended team such as specialists and care workers in the community and across care transitions. You also need the ability to track and document what you have communicated and collaborated."

By implication, a PCMH must be able to give patients information and data about themselves in a timely manner. That could take the form of a printed report or, for the more tech-savvy patient, a personal health record (PHR) that could be accessed and distributed electronically.

In addition, a key PCMH criterion specifies the ability to open your practice for extended access by patients. That may be addressed by scheduling systems or a portal through which patients can communicate with the practice.

Practice experience

Five physician organizations interviewed for this paper explain in more detail how their use of IT helps them achieve their PCMH goals.

Systemizing comprehensive care

In February 2009, James Holly, MD, co-founder and CEO of Southeast Texas Medical Associates (SETMA), attended a workshop introducing the concept of the medical home. He left the meeting unclear about what being a medical home meant, but determined to learn.

To this end, SETMA, a multi-specialty clinic, performed a comprehensive analysis of its operations. While SETMA had focused on disease management during its EHR implementation, its future plans to improve patient-centered care – and apply for NCQA PCMH recognition – called for a new approach. Dr. Holly understood that it would require scrutiny of patient-care data in order to change provider and patient behavior; change practice procedures and processes; and improve patient health through a focus on preventive care.

By seeking PCMH Level 3 recognition, the highest level, SETMA saw an opportunity to:

- incorporate national quality-of-care standards into the EHR and workflow;
- use tools at the point of service to enable evidence-based medical care;
- measure provider performance in real time; and
- examine patterns of care and outcomes using statistical methodologies.

SETMA achieved Level 3 recognition in July 2010. Reflecting on the accomplishment, Dr. Holly comments, “To reach PCMH recognition, a practice must provide patient communication with a personal physician who accepts full, primary responsibility for each patient’s care. It includes efforts such as answering health-related inquiries at any time; providing telephone access with same-day response and facilitating email contact through secure Web portals. Continuity of care in the electronic age also involves making each patient’s record available at every point of care – clinic, hospital, emergency department, nursing home, healthcare provider’s home and others.”

A health information exchange launched by SETMA provides accessibility to the patient chart by hospitals, emergency rooms, specialists and primary care providers. SETMA’s Web portal lets patients maintain and periodically review their own PHR. In addition, a written and personalized “plan of care” and “treatment plan” are provided to the patient at each clinic visit. A “transition of care” analysis is done each time the patient moves from one level of care, such as from hospital in-patient care to ambulatory care. This analysis, based on national standards of care for transition, provides the patient written, reconciled medication lists; detailed follow-up instructions; and personalized self-care information. “It places patients at the center of their healthcare decision-making processes, which encapsulates the PCMH ideal,” says Dr. Holly.

SETMA’s self-assessment and journey to PCMH recognition meant moving from meeting national standards solely on a patient-by-patient basis to measuring treatment across

A Comprehensive Model of Care

“In its best iteration, comprehensive care includes wellness, healthy lifestyle, health-risk appraisal and prevention, as well as end-of-life issues, all of which are part of the continuum of care. It’s not just coordinated, it is comprehensive, and that’s critical,” says James Holly, MD, co-founder and CEO of SETMA, a multi-specialty clinic that has successfully achieved medical home status from NCQA and the Accreditation Association for Ambulatory Health Care.

Using real-time data and benchmarking tools, SETMA has developed its Model of Care, which provides a framework for analyzing, making informed decisions and continuously improving the quality of care, according to Dr. Holly.

Here is a summary of key aspects of the Model of Care.

Tracking — Each provider tracks performance of preventive, screening and quality standards for acute and chronic conditions while in the exam room with each patient. Tracking occurs simultaneously with the provision of care by members of the entire healthcare team (e.g., physicians, nurses, clerks).

Auditing — Over a given patient population, audits examine care patterns by provider, practice or the entire clinic — with an eye toward identifying ways to improve care processes. The audits utilize business intelligence functionalities to identify trends and patterns of care and to look for leverage points through which population care can be improved. SETMA believes auditing and statistical analyses are the essential pieces missing from most healthcare improvement auditing programs.

Analyzing — The clinic statistically analyzes performance audits to measure improvement by practice, clinic or provider. This is how SETMA understands the meaning behind its processes and outcomes measures. Analysis focuses on any care discriminators — such as ethnic, age, gender, payer or treatment frequency disparities — to identify leverage points for care improvement.

Reporting — SETMA publicly reports hundreds of quality measures per provider on its Web site. The goal is to motivate improved performance by providers and increased confidence among patients. Patients also receive documented plans of care to help empower their own healthcare involvement. All reporting functions are designed to overcome both provider and patient-treatment inertia.

Improving — The clinic uses its analysis tools to identify appropriate quality initiatives to pursue. One current initiative, for instance, involves the elimination of all ethnic diversities of care for diabetes, hypertension and dyslipidemia.

Dr. Holly concludes, “SETMA continues using innovative technologies and processes to more completely transform SETMA’s Model of Care into a robust PCMH.”

broad patient populations. In doing so, SETMA laid the cornerstone for the program it now calls the SETMA Model of Care, encompassing the areas of data-tracking, auditing, analysis, reporting and improvement. (See sidebar titled "A Comprehensive Model of Care" for more details.)

Ensuring safe transition of care

The Hudson Valley Initiative (HVI) in New York is helping physician practices adopt EHRs and make the transition to PCMHs. More than 700 HVI-supported providers have adopted EHRs, and 305 had transformed their practices into PCMHs as of January 2011.⁵

Holly Miller, MD, chief medical officer for MedAllies, a health information services provider that works with Hudson Valley practices to improve efficiency and effectiveness of care through the use of IT, points out that you cannot achieve true care coordination and a PCMH without an EHR. At the same time, in order to support patients across transition-of-care environments, disparate EHRs must be able to send and receive patient information in a point-to-point fashion. "In terms of true care coordination across transition of care, we strongly believe that information must flow to the providers who are caring for the patient as necessary," says Dr. Miller.

Through a pilot program called the Direct Project, a national effort to "fast-track" electronic health exchange under the direction of the Office of the National Coordinator for Health IT, a new medication regimen given to a patient at the time of hospital discharge would flow from the hospital EHR system to the patient's primary care physician (PCP)'s EHR before the patient has even walked out the hospital's doors.

"When discharge information goes into the PCP's EHR, it can be distributed to the caregivers for that patient in a PCMH model, consistent with the practice's standard EHR workflow" explains Dr. Miller. "That could be distributed to a nurse care manager who's trying to manage that patient and to a scheduler to make an appointment with the primary care doctor, as well as to the patient's PCP. So the nurse care manager can call the patient the day the patient arrives home to review the new medication regimen, ensuring a safe transition from the in-patient to the home environment."

Reporting on evidence-based practices and ED visits

Jim Stape, practice manager for Gilbert (Arizona) Center for Family Medicine, a PPC-PCMH Level 3 practice, highlights care-management reporting as a key IT-enabled function. Gilbert produces about 60 care-management reports, broken down into three main areas. The reports pull core information from the practice's EHR.

"We look at the care management done by our employees and we monitor their completion of their portion of the care-management picture," says Stape. "We also have a set of

reports that shows how the provider is doing in terms of his care of patients."

The third set examines the patient's progress in the arena of care management. "For instance," Stape continues, "we monitor our diabetic patients to track their hemoglobin A1c numbers, looking particularly for patients who have readings above 9. Those are the folks who need serious attention or are out of control. We can see how we're doing as a practice overall, and we can report down to the provider level to see a specific provider's distribution of A1c results. And finally, we can report on patients' individual results."

In addition to A1c results, Gilbert reports on other areas for its diabetic patients. "We monitor annual screening for retinopathy, nephropathy and foot exams," says Stape. "We also report on control of their lipids panel and blood pressure."

The practice then compares its results against HEDIS figures for the Western portion of the United States. Stape notes, "In all areas other than retinopathy, we're at 90 or above in percentile, compared to the Western states. We're at 75 percent with retinopathy, and we're working on it."

Stape adds that patient education is mandatory for all of Gilbert's newly diagnosed diabetic patients; it's provided in-house by the practice's medical secretary. Gilbert also requires patient education for poorly controlled diabetic patients, who are referred to programs outside the practice.

In the event that a Gilbert patient winds up in the emergency department (ED) at a facility of Banner Health, the largest hospital chain in Gilbert's area, technology helps make a connection back to the home practice. "Banner emails us with notification of all ED visits," says Stape. "They also email us with notifications of in-patient activity and radiology studies."

Gilbert recently approached Catholic Health West, the second largest chain in the area, with a similar request. "Now we can log onto their system and see a queue every morning that lists all of our patient activity in their hospital chain over the past 24 hours," Stape explains. "That information is electronically added to our EHR."

Gilbert plans to expand its PCP-notification initiative to include a third area hospital chain.

Importing clinical information

Greg Spencer, MD, was the second internist hired by Crystal Run Healthcare in New York state when the practice was formed in 1996. "We had about nine physicians total and about 30 employees," recalls Dr. Spencer. "Even as late as 2002, we were still in the 25-doctor range. We're now at

Program Puts P4P in Practice

The New York City Health Department's Primary Care Information Project (PCIP) seeks to improve the quality of care in underserved communities through the use of health IT. Supported by \$60 million in city, state, federal and private funds, PCIP aims to improve the health of New Yorkers by facilitating the adoption and use of EHRs among the city's PCPs. The project focuses on the New York neighborhoods where health disparities are greatest — East and Central Harlem, the South Bronx and Central Brooklyn.⁶

In 2009, the NYC Department of Health and Mental Hygiene (DOHMH) launched Health eHearts, a pilot incentive program privately funded by the Robin Hood Foundation. The \$6 million two-year pilot rewards and recognizes EHR-enabled practices for improving cardiovascular health in patients. DOHMH describes eHearts as a pay-for-performance (P4P) program that uses EHR-generated clinical quality outcomes to reduce health disparities.⁷

According to Amanda Parsons, MD, MBA, assistant commissioner of PCIP at the DOHMH, practices enrolled in eHearts can receive up to \$25,000 per quarter in P4P incentives based on practice-level achievement on a core set of cardiovascular health quality measures known as "the ABCS."

"A" stands for aspirin therapy, and measures patients whether 18 years or older with ischemic vascular disease (IVD), or patients 40 years or older with diabetes, are on aspirin or another anti-thrombotic therapy.

"B" stands for blood pressure (BP) control and measures patients whether 18-75 years of age with hypertension, and without IVD or diabetes, have BP less than 140/90; patients 18-75 years of age with a diagnosis of diabetes and hypertension have their most recent BP below 130 systolic and 80 diastolic; and patients 18-75 years of age with a diagnosis of IVD and hypertension without diabetes have a BP below 140 systolic and 90 diastolic.

"C" stands for cholesterol control and measures whether male patients over 35 and female patients over 45 without IVD or diabetes have had a total cholesterol reading of less than 240 or an LDL reading of less than 160 measured in the past five years; and whether patients 18-75 with a diagnosis of IVD or diabetes and lipid disorder have had an LDL reading of less than 100 in the past 12 months.

"S" stands for smoking cessation and measures whether patients 18 years or older identified as current smokers have received cessation interventions or counseling.

eHearts requires automated reporting of these measures to PCIP on a monthly basis, and participating practices must use an EHR to provide the reports. Dr. Parsons notes that standard functionality of current EHRs enables collection of the required data, calculation of the measures and transmission of the results to PCIP.

The use of data derived from the EHR is a novel piece of eHearts, says Dr. Parsons. "Most quality-incentive programs run off of claims data, because frankly that's all that payers have in terms of good information on what actually happened at the point of care. Now, EHRs enable a new way of doing pay-for-performance. They enable you to pay based on quality metrics or process measures that have been performed during the care encounter."

It's important to note that DOHMH provides feedback to participating eHearts practices through summaries of provider- and practice-level achievement on the ABCS; however, the quality reports are not shared publicly, and no patient-identifiable data is used. "The reason we collect the data is to use it from a data-decision point of view — to be able to assign the right resources to the right providers to meet their needs, but also to be able to give them back a quality dashboard and information about how they provide care," explains Dr. Parsons. "PCIP does not share provider data with third parties unless the practice explicitly authorizes them to do so, and that's why providers trust PCIP with their data."

"Remember that prior to the adoption of EHRs, most providers had never seen a quality report that spanned their entire patient population," she continues. "Providers relied on random reports from different payers. It's like going through college without ever getting a transcript...and doing that for the rest of your life. [Through this program], for the first time, you get to see a transcript. You get to see how you're doing: What are you struggling with? What are you doing well? And we can help you adjust accordingly."

about 200 doctors and 1,300 employees. I feel that the EHR and having an IT infrastructure has significantly contributed to our explosive, yet controlled, growth.”

According to Dr. Spencer, Crystal Run has been using an EHR since 1999, and that played a role in the practice’s intention of becoming a Level 3 PCMH. “All of the highest-level goals within each of the requirements called for an electronic medical record. But it wasn’t easy; we had to re-think some of our workflows.”

Dr. Spencer explains that Crystal Run has separate radiology and laboratory information systems. “We use the EHR as the final common repository for all that information so there is one place to look for things.” He adds, “Everyone taking care of the patient shares a common record and a common database of information. We don’t have issues of not knowing where to look for things. Also, there’s less duplication. If an endocrinologist ordered a test for diabetes three weeks ago, I don’t have to repeat it. I can use that information in my care of the patient as well.”

Improving practice operations

Mike Yerrid, chief information officer at Medical Clinic of North Texas (MCNT), a Level 3 PCMH practice in the Dallas-Fort Worth area, says participating in medical home projects has enabled MCNT to provide better overall care to patients. One innovation that grew from the PCMH effort was the implementation of “huddles” at some MCNT offices.

“The physicians meet with their staff during the day to review the patients that are coming in,” Yerrid explains. “They go over treatment plans and what work needs to be done for the patient. As a result, the nurses are more empowered to make decisions and to perform care under the doctor’s specifications even before the doctor is available to go in and see the patient. For example, they already know that the patient needs to have certain labs drawn or needs to have certain immunizations.”

MCNT also distributes visit summaries to each patient, with information drawn from the EHR after the patient’s encounter with the physician. “That has helped to eliminate a lot of the questions that come up after a visit,” Yerrid continues. “The summary can be printed out and handed to the patient or it can be accessed electronically by patients who have signed up to use MCNT’s patient portal.

“One of the principles of PCMH is to provide patients with timely and convenient access to care and their health information,” says Yerrid. “NextGen® Patient Portal helps us in this regard.” Each month, MCNT receives approximately 400-500 appointment requests, 700-800 medication refill

requests and 2,000 patient messages. “All of these are initiated by patients at a time that is most convenient for them,” notes Yerrid. “It reduces the phone calls to our offices, minimizes the interruptions for our staff and improves the efficiency of processing and documenting patient communication in the chart.”

The portal enables MCNT to initiate communication with patients, too. Physicians and staff use NextGen Patient Portal to check the status of non-critical health problems, for example. “We send patients lab letters and copies of their test results as well as visit summaries via NextGen Patient Portal instead of mailing them. If patients need immunization summaries or return to work/school documents, we can send those through NextGen Patient Portal as well,” says Yerrid. “All of this provides more timely access to information and provides a better service to our patients.” Automatic reminders sent via NextGen Patient Portal also encourage patients to keep their appointments.

Getting prepared for the PCMH

So where do you start if you haven’t already begun preparing for the PCMH model?

Dr. Blatt from Intel points out that in all of the previously mentioned use cases, the EHR needs to be interoperable. “You could do some of it with standalone component systems, but putting it all together outside a comprehensive package would be very difficult,” he observes.

If you choose to pursue the PCMH model, your first step should be performing a gap analysis: Look for the overlap between the meaningful use and PCHM criteria (e.g., demographics, e-prescribing and patient communications). “It’s in your best interest to implement that functionality because you are going to get paid for it under meaningful use,” notes Dr. Blatt. “As you address some of the more contentious criteria – probably part of meaningful use Stages 2 and 3 – think about phasing them in.”

Also, with a transition from paper to electronic information, you’ll need to draw up a strategy to ensure security of the EHR in the various forms on which it will reside. It could be on your cell phone, a smartphone, a mobile device, a notebook, a desktop or a server back at your practice. “Everybody gets their own laptop when they join our practice,” says Crystal Run’s Dr. Spencer. “When people are on call or at the hospital, they have separate remote-access credentialing. We make sure that they know what that means and they know how to use it.”

And remember that EHR automation will proliferate at a much higher percentage rate over the next several years.

Encryption of protected health information will give you the flexibility to put your information on different form factors; and it will give you the ability to prove the security of your information, audit it remotely, document it and wipe it clean if necessary (as in the case of lost or stolen equipment).

Naturally, your CFO will want to discuss how you expect to get paid from this emerging model of care. Will your predominant payer community be interested in rewarding your practice preferentially if you achieve the sophistication of Level 3 PCMH? You should also watch for promising pay-for-performance (P4P) opportunities, exemplified by New York City's eHearts program described in the sidebar "Program Puts P4P in Practice."

At the same time, recognize that vendors are motivated and focused to assist physician practices with EHR implementations as the foundation of care-improvement initiatives. With incentive dollars on the line for their customers, vendors are concentrating on putting more depth and breadth into what were formerly "standard" EHR implementations. They're even willing to collaborate with competitors, as demonstrated by the Direct Project.

Finally, don't forget to access your closest Regional Extension Center (REC). The Office of the National Coordinator for Health IT has funded 62 RECs to help more than 100,000 PCPs meaningfully use EHRs. RECs have \$677 million for the next two years to support their work.⁸ "Our practice is a certain portion of the way through the PCMH process, and we have no problem sharing the experiences we've had," says Stape of Gilbert Center for Family Medicine, which utilizes its REC. "We'll certainly look at other practices who might be more advanced than we are. It's great to make those kinds of contacts to get ideas. You may end up being steered in a direction you hadn't considered...or someone may stop you from repeating a mistake they made."

Physicians increasingly accept that EHRs and related technologies will help them take better care of their patients. The time is right to work through questions and concerns so you can morph from your current standard to the new PCMH landscape in a logical fashion.

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