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Medical Home Part IX
Radical Changes in Healthcare Delivery
A Slow and Continuing Process
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The foundation of the Patient-Centered Medical Home has been laid in the first eight parts of this series which began on February19, 2009. In these first eight articles, we have reviewed the concept of, the content of and the changes in healthcare delivery which result from the introduction of Medical Home. Like any new idea which has validity, Patient-Centered Medical Home will not only result in changes based on the current standards required to achieve recognition but those changes will expand as they result in unintended consequences which will improve the processes of healthcare delivery.

This is illustrated in something as simple as patient education and provider examination. As SETMA's Registered Dietician reviewed SETMA's Medical Home Coordination Review tutorial – which when completed will be over 100 pages long – she commented that she hoped the day would come when patient education would be a part of the evidence-based measures which are the content of quality improvement resulting from the requirements of medical home recognition.

Here is part of that discussion

"I (Dr. Holly) will forward your ideas to NCQA, as I agree with you as to the importance of diabetes education and of the value of the Registered Dietitian in regard to the management of

- Hypertension (DASH – Dietary Approach to Stop Hypertension -- diet),
- Lipid management (low cholesterol, low triglyceride diets) and
- To the imperative of effective weight management in regard to diabetes, hypertension and lipid management.

"Another area in which I hope SETMA can influence NCQA for HEDIS measures and Medical Home, as well as NQF, Physician Consortium and PQRI is in regard to the measurement of the blood pressure in the treatment of hypertension. The following steps would improve the standardization of blood pressure values:

1. Repeating the blood pressure if it is elevated at any visit – already a part of Physician Consortium Hypertension Data set but not HEDIS, NQF or PQRI
2. Measuring the size of the bicep and calculating and documenting the size of blood pressure cuff which should be used and then which was used in taking the blood pressure. Not a part of any quality measure at present, but a critical step in accurate blood pressure measurement.

3. Documentation that the blood pressure was taken with the patient seated in a chair rather than on the examination table. Not a part of any quality measure at present, but an evidence-based standard in accurate blood pressure monitoring.

"Like patient participation in ADA approved Diabetes Self Management Education (DSME) and like patients receiving Registered Dietitian instruction for the DASH diet, and Weight and Lipid Management, each of these steps would raise the standard for treatment of hypertension and the measurement of the patient's blood pressure, which is one of the most "subjective" objective data points in the patient evaluation.

"June rapidly approaches as SETMA begins the practice of Medical Home, as does July when we will begin reporting data for PQRI. I am proud that you and other Diabetic educations and Registered Dieticians are part of the SETMA team."

"Standards and Guidelines for Physician Practice Connections Patient-Centered Medical Home"

This is the title of the National Committee for Quality Assurance's (NCQA) manual which describes the 9 standards, 30 elements and 83 data points which are part of the recognition process for Medical Home. As one examines this description of Medical Home, it involves many functions which are not currently part of how healthcare is delivered in America.

In education, a standard, or test, should teach as it examines, in other words, a student should come away from a test with a clear idea of what is important to know and how well the student knows that material. Typically, a test will be weighted to where the most important and often the most difficult material is given additional weight in the scoring of the test, i.e., the more important the material the higher a total score will be for knowing that material.

With the standards for recognition as a Medical Home, that is not always the case. For instance, often the elements and data points within each standard are weighted such that the potentially most valuable functions of the Medical Home are given the lowest value within the total score. Why would this be the case? Principally, it appears that it is because the most valuable functions of the Medical Home process are often the most novel and also often the most difficult to develop in the Medical home model of care delivery. Therefore, Medical Home recognition at the lowest level, Tier I, can be achieved without performing some of the most difficult functions of Medical Home, but are built into the standards as the impetus for practices to start moving toward fulfilling some of these more difficult and complex functions.

What are some of these functions?

Of the 9 NCQA Medical Home Standards, Standard Number 1is entitled "PPC 1: Access and Communication." In a total possible score of 100, this standard has a value of 9

points. Standard 1 has two elements; Element A has a weighted value of 4 points and Element B has a value of 5 points.

In order for a practice to receive all 9 points, it must fulfill 9 of 13 data points in Element A and 5 of 5 in Element B. The complexity of this Standard will be appreciated by noting that the 13 data points in Element A include the requirement that the practice has written processes for functions such as:

- Coordinating visits with multiple clinician and/or diagnostic tests during one trip.
- Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time
- Providing an interactive practice Web site
- Making language services available for patients with limited English proficiency
- Identifying health insurance resources for patients/families without insurance

The other 7 data points within Element A are more traditional medical practice functions. These 5 data points are all valuable and are therefore included to move practices forward in the radical change of healthcare delivery processes which is the goal of Medical Home. However, because they are relative new functions, all of them are not required at present but they give a medical practice a goal to pursue.

Standard Number 2

Standard Number 2 of the NCQA recognition process is entitled "PPC 2: Patient Tracking and Registry Functions." This standard has a weighted, total value of 21 paints within the 100 total potential points. There are six elements within this Standard and each element has multiple data points.

An illustration of the change in process which Medical Home generates is seen in Element F which is entitled, "Use of System for Population Management," and which has 7 data points. Element F has a total potential value of only 3 points. Again, this does not represent its potential value to a patient but it reflects the novelty of some of the functions defined in this element. Four of these data points are:

"The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed as follows:

- Patients needing pre-visit planning (obtaining tests prior to visit, etc.)
- Patients needing clinician review or action
- Patients needing reminders for follow visits such as for a chronic condition
- Patients who might benefit form care management support"

Each of these data points is obviously valuable to the patient-care process, but each is also a relatively new function which is being introduced to the Medical Home practice. As a result, not all of these functions need to be present in order to qualify for a Medical

Home Recognition at present, but the goal is that any practice which gains Medical Home recognition will begin developing these functions.

Standard Number 3

One last point illustrates this principle. NCQA Standard 3 is entitled, “PPC-3: Care Management,” has 5 elements and has a weighted value of 20 points within the total of 100 points possible.

One of the requirements of Medical Home is for the practice to select three clinically important conditions upon which the practice will report to NCQA. SETMA has chosen diabetes, hypertension and lipid management. Element D of Standard 3 is entitled, "Care Management for Important Conditions.” There are 11 data paints in this element. In order to receive the full 5 points which is possible for Element D, the practice must demonstrate that 75% or more of patients seen in the three months prior to application have at least 4 of these 11 data points documented.

As you read Element D’s 11 data points, you would judge that they are extremely valuable to the patient’s care, but you would also judge that they are difficult to perform. They include functions such as:

- Conducing pre-visit planning with clinician reminders
- Writing individualized care plans
- Writing individualized treatment goals
- Following up when patients have not kept important appointments
- Reviewing longitudinal representation of patient’s historical or targeted clinical measurements.
- Completing after-visit follow-ups

These are valuable functions and it is the goal of Medical Home that they will be developed but because they represent significant resource allocation and personnel effort, they only represent 5 points out of 100 and only 4 of the data points have to be documented 75% of the time to gain those 5 points.

SETMA’s Goal and SETMA’s Assessment of the Medical Home Process Changes

SETMA is redesigning practice workflow with the intent of fulfilling all 9 standards, 30 elements and 83 data points of NCQA Medical Home recognition. However, we recognize that even for us some of them are difficult.

To do Medical Home “right,” it is our estimate that it will take a full-time care coordinator – which will be a new employee to a medical practice -- for every 1500 active participants in Medical Home. In addition, a MSW (social worker) will be required for every three care coordinators.

It is expected that it will take 12-24 months to initially create the new Medical Home database completely and thoroughly. After that it can be maintained and new patients added concurrent with initial care.

The above personnel need is calculated on the basis of a care coordinator giving ninety minutes of attention per year to facilitating, tracking and monitoring the care of each person in their unit. The MSW will be available for home assessments and counseling in more complex cases. It is expected that 20% of the Medical Home members will need this level of attention, giving the MSW 2.2 hours per year with each of this group.

Weekly care-coordination conferences will be held about active, unsolved coordination of care problems identified by healthcare providers, support staff, care coordinators or MSW. Those conferences can be held with lunch being provided so that it maximizes the time utilization of all members of the team.

A Final Thought

We don't believe for a minute that Medical Home is going to decrease the work of primary care providers and shorten their days. Increased satisfaction? Yes. Improved outcomes? Yes. Cost improvement? No doubt. Less work? In the words of the Scotsman, who was buying a used car from a customer, when he asked the man how much he wanted for the car, his response to the answer was, "Silly boy!!!"