Medical Practice Transformation:

A Comprehensive Overview of Strategies and Change Concepts for Achieving PCMH in Georgia
Defining PCMH

http://youtu.be/fW8amMCVAJQ
Defining PCMH

- Model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” (comprehensive, coordinated, accessible, quality)

- Clinicians, insurers, purchasers, consumer groups and others know the patient-centered medical home is a proven alternative to the nation’s costly, fragmented delivery system.

- Research confirms that medical homes can lead to higher quality and lower costs, and can improve patient and provider experiences of care

Source: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
History of PCMH

- **1967**: AAP first introduced the term as a central source for all medical information about a child
- **1978**: WHO defined key principles of the medical home
- **1990’s**: AAP policy statement defined medical home as “family-centered”, “continuous”, and “coordinated”; more frequent use of the term by IOM
- **2001**: IOM Crossing the Quality Chasm
- **2002**: Future of Family Medicine
- **2004**: Literature predicting reduced costs, national increased savings, increased quality, better health outcomes, reduced health disparities
History of PCMH

- **2005**: ACP developed “Advanced Medical Home” focused on evidence based medicine, clinical decision support, HIT, and performance feedback
- **2006**: Inception of the Patient Centered Primary Care Collaborative organization to promote medical home model
- **2007**: Joint Principles of PCMH released by AAFP, AAP, ACP, AOA
- **2008**: NCQA releases PPC-PCMH to recognize physician practices as PCMH
- **2010**: Key HIT domains identified as necessary for success of the PCMH Model
- **2011**: NCQA releases new standards with heavy emphasis on meaningful use and pediatrics
Integrating PCMH in Practice Operations: Key Focus Areas

- Enhanced Access and Continuity of Care
- Population Management
- Planning and Managing Care
- Self Care Support
- Tracking and Coordinating Care
- Measuring and Improving Performance
Common Questions about PCMH: NCQA Recognition Logistics

• 3 levels of recognition (1,2,3) based on accumulation of points

• The higher the level the greater the emphasis on meaningful use

• Recognition is for three years

• Multi-site recognition based on set criteria
Integrating PCMH in Practice

Operations: Methods for Integration

• Establish a leadership team to champion change and ensure sustainability

• Establish regular meeting times to assess, make changes, and develop policies and prescriptive procedures

• Create/update job descriptions

• Educate, motivate, and mobilize staff

• Align your resources
Common Questions about PCMH: Time Commitment

• 6-18 months depending on practice aggressiveness

• Leadership team assembly

• Regular PCMH meetings to discuss process, procedures, and documentation requirements

• Level of proficiency utilizing the EMR
Resources Needed to Achieve PCMH Recognition

- Value of You (Leadership Team)
- EMR
- CMS Meaningful Use
- Staff Time
- Community Resources
- Patient Portal
- Practice Website
Common Questions about PCMH: Costs

• Biggest cost: EMR (purchasing/training may be required)
• Allocation of staff time and resources
• Application: $80 for the survey tool, $550 per provider
• Consultant (optional)
• Marketing of the practice and providers once recognition obtained (NCQA Website)
• Enhanced reimbursement from third parties
• Consider money saved (reduce waste, staff performance) and increased revenue
• Enhanced earning potential in incentive programs due to better cost and quality performance
Common Questions about PCMH: Benefits for the Practice

• Operational efficiency (Huddles, pre-visit planning, streamlined job functions, structured communication internally and externally)
• Reduced patient cycle times
• Improved patient flow
• Enhanced staff satisfaction; Reduced staff turnover (more emphasis on team)
• Improved HEDIS performance
• Development of sound policies and procedures around most important conditions
Common Questions about PCMH: Benefits for the Patient

- Enhanced patient engagement
- Less wait time
- Enhanced accessibility
- Knowledge of community resources and services
- Reduced inpatient admissions
- Decreased ER utilization
- Positive health outcomes
Sustaining PCMH in Practice

Operations

• Continue to utilize EMR generated reports for population management and performance monitoring
• Set goals for performance improvement
• Incorporate incentives
• Maintain your leadership team
• Annual review of policies and procedures
• Annual training/refresher and professional development for staff
• Leveraging PCMH reimbursements
PCMH Resource List

• Safety Net Medical Home
  – http://www.safetynetmedicalhome.org/

• NCQA PCMH Recognition
  – http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

• Patient Centered Primary Care Collaborative – PCPCC
  – http://www.pcpcc.org/

• AAP – PCMH
  – http://www.pediatricmedicalhome.org/